TEXT OF AN UNCLASSIFIED MESSAGE FROM THE CHIEF OF NAVAL OPERATIONS TO ALL COMMANDERS (Disseminated in 1987)

SUBJECT: SUICIDE PREVENTION PROGRAM.

1. I AM DEEPLY CONCERNED ABOUT THE THE CONTINUED INCIDENTS OF ATTEMPTED AND COMPLETED SUICIDES IN THE NAVY. WE MUST CONTAIN AND ATTEMPT TO REDUCE THE NAVY SUICIDE RATE. IN 1986, ELEVEN PERCENT OF ALL NAVY CASUALTIES WERE SUICIDES. SEA SERVICE LIFE IS STRESSFUL FOR ALL AGE GROUPS. OUR YOUNG MEN AND WOMEN, HOWEVER, MAY BE PARTICULARLY VULNERABLE TO OPERATIONAL PRESSURES AND PERSONAL INSECURITIES. THERE HAS ALSO BEEN AN INCREASE NATIONALLY OF YOUTH SUICIDES. SUICIDE AWARENESS AND CRISIS ASSISTANCE RESOURCES ARE WIDELY AVAILABLE THROUGHOUT THE NAVY AND THE CIVILIAN SECTOR. WE NEED TO USE THESE RESOURCES MORE SYSTEMATICALLY. TO THAT END, I AM DIRECTING SEVERAL ACTIONS TO INITIATE A NAVY-WIDE SUICIDE PREVENTION PROGRAM.

2. EFFECTIVE IMMEDIATELY, ALL COMMANDING OFFICERS WILL ENSURE THAT BOTH LOCAL MILITARY AND CIVILIAN CRISIS ASSISTANCE RESOURCES ARE ADEQUATELY HIGHLIGHTED DURING COMMAND ORIENTATION SESSIONS FOR NEWLY REPORTED PERSONNEL. COMMANDS WILL BE RESPONSIBLE FOR COUNSELING ALL MEMBERS WHO ARE SUBJECT TO SIGNIFICANT PROFESSIONAL AND PERSONAL PROBLEMS (E.G. CAREER, FAMILY, FINANCIAL, ETC.) AND ENSURE THAT THEY RECEIVE APPROPRIATE ASSISTANCE. WITHIN 120 DAYS, THE CHIEF OF NAVAL PERSONNEL WILL INSTITUTE ONGOING, SYSTEMATIC SUICIDE AWARENESS EDUCATION WITH TWO MAJOR COMPONENTS: 1) PROVISION OF SUICIDE INFORMATION PACKETS TO ALL COMMANDING OFFICERS AND 2) SUICIDE AWARENESS TRAINING FOR COMMAND MID/UPPER LEVEL SUPERVISORS, ALL ACTIVE DUTY ENLISTED/OFFICER ACCESSIONS AND FAMILY MEMBERS, WIVES CLUBS, ETC. FAMILY SERVICE CENTERS (FSC) IN COOPERATION WITH THE LOCAL MEDICAL TREATMENT FACILITIES AND CHAPLAINS WILL COORDINATE THIS TRAINING. WHERE THERE ARE NO FSCS, COMMANDING OFFICERS WILL BE RESPONSIBLE FOR COORDINATING THE TRAINING. THE CHIEF OF NAVAL EDUCATION AND TRAINING WILL ENSURE AVAILABILITY OF BRIEFING SLOTS IN ALL ACCESSION PROGRAMS. WITHIN 120 DAYS, THE CHIEF OF NAVAL INFORMATION WILL DEVELOP SUICIDE AWARENESS INFORMATION FOR RELEASE THROUGHOUT NAVY MEDIA CHANNELS. THE DIRECTOR MEDICAL MEDICINE WILL CONTINUE TO EMPHASIZE GUIDANCE OUTLINED NAVMEDCOMINST 6520.1A, "EVALUATION AND DISPOSITION OF PATIENTS PRESENTING WITH SUICIDAL IDEATION OR BEHAVIOR" AND WILL ALSO PROVIDE CONSULTIVE SUPPORT FOR VARIOUS ACTIONS DIRECTED ABOVE.

3. PEOPLE ARE OUR MOST IMPORTANT ASSET. GOOD LEADERSHIP AND CONCERN FOR OUR SAILORS WILL ASSIST IN THE CONTAINMENT AND REDUCTION OF SUICIDES IN THE NAVY.

DEPARTMENT OF THE NAVY
COMMANDER
NAVAL BASE PEARL HARBOR
BOX 110
PEARL HARBOR, HAWAII 96860-5020

IN REPLY REFER TO
1752
Ser NQOL2/

9 AUG 1993

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

Dear Mr. Moldeven:

We applaud your efforts to address the crucial issue of suicide intervention and prevention in the Armed Forces. Our efforts here have included the enclosed Commander, Naval Base, Pearl Harbor Instruction which provides information on suicide prevention, stress reduction, and critical incident stress debriefing.

The principal writer of this instruction was Lieutenant Commander John S. Reibling, Medical Service Corps, USN. He can be reached at (808) 474-4749.

We wish you continued success in your work.

Sincerely,

JAMES K. CHUN
By direction

Enclosure

DEPARTMENT OF THE NAVY
COMMANDER
NAVAL BASE PEARL HARBOR
BOX 110
PEARL HARBOR, HAWAII 96860-5020

IN REPLY REFER TO
COMNAVBASEPEARLINST 6520.1
00M:NKT:jsr
5 AUG 1991

COMNAVBASE PEARL INSTRUCTION 6520.1

Subj: SUICIDE PREVENTION AND OCCUPATIONAL MENTAL HEALTH PROGRAM

Ref: (a) NAVMEDCOMINST 6520.1A (NOTAL)
(b) OPNAVINST 1500.22D
(c) MILPERSMAN 420100
(d) Hawaii Revised Statutes 334-59

Encl: (1) Understanding and Managing Suicidal Behavior
(2) Stress Management Techniques
(3) Command Consultations and Critical Incident Stress Debriefings
(4) Points of Contact

1. Purpose. To establish suicide prevention training, stress management training, and a program for assisting commands in coping with the aftermath of critical incidents, within Commander, Naval Base, Pearl Harbor's (COMNAVBASE Pearl) region of responsibility (Hawaiian Region). The primary goals of this instruction are to promote healthy coping strategies, to increase awareness of the signs and symptoms of potentially suicidal behavior, and to encourage early intervention in assisting individuals either identified to be at risk for suicidal behavior, or identified as having been potentially affected by a critical incident.

2. Background

a. Every person in the Navy family has the potential to come in contact with a person who is at increased risk of suicide. It follows that early identification and intervention in preventing suicide is the responsibility of all naval personnel.

b. Crucial steps in the suicide prevention process are an awareness of life stress events that put individuals at risk as well as an awareness of the signs and symptoms of a person at risk.

c. It is the assumption of this instruction that commands can significantly reduce the risk of suicides and adverse reactions to critical incidents by promoting preventive efforts as described herein.

3. Action

a. Installation commanders will ensure training in the following subject areas is made routinely available to all naval personnel on installation:

(1) The prevention and management of suicidal behavior. Enclosure (1) provides detailed information.

(2) Stress management. Enclosure (2) provides detailed information.

b. The Commanding Officer, Naval Medical Clinic, Pearl Harbor, will provide:

(1) Command consultations and critical incident debriefings, as requested by unit commanders, per enclosure (3).

(2) Management of suicidal patients per reference (a).

(3) Assessment and advice to unit commanders on noted trends and stress factors brought to the Clinic's attention as a result of assessments of patients from that unit.

(4) Assistance to Directors of Installation Family Service Centers in providing suicide awareness training, as needed.

c. Directors of Installation Family Service Centers will provide:

(1) Training on the prevention and management of suicidal behavior, as suggested in enclosure (1), as requested by individual service members, unit commanding officers, and base security officers.

(2) Stress management training, as suggested in enclosure (2), as requested by individual service members, unit commanding officers, and base security officers.

d. Unit commanders will:

(1) Ensure all personnel within the command receive training every 24 months on:

(a) Prevention and management of suicidal behavior as suggested in enclosure (1).

(b) Stress management, per reference (b) and as suggested in enclosure (2).

(2) Report all suicides and attempted suicides per reference (c).

e. Installation Security Officers will:

(1) Ensure all police personnel receive annual training as suggested in enclosures (1) and (2).

(2) Establish liaison with local military and civilian crisis agencies, such as the Suicide and Crisis Center, to coordinate assistance efforts when needed. Enclosure (4) lists points of contact.

(3) Ensure all police personnel receive specific training in the handling of situations involving civilians considered at risk for self-harm. Reference (d) applies.

f. Installation and unit Senior Chaplains will:

(1) Advise installation and unit commanders on moral and ethical issues and other stress factors that may result in an increased number of people at risk.

(2) Assist commands and directors of Installation Family Service Centers in providing training, as needed.

g. Commander, Naval Base, Pearl Harbor (Code 013) and Installation Public Affairs Officers will ensure regular publication of suicide prevention and awareness information in appropriate military publications.

4. Strategy

a. The strategy and supporting elements of the Suicide Prevention and Occupational Mental Health Program are based on the premise that suicide prevention and the prevention of debilitating reactions to critical incidents will be accomplished by leaders through command policy and action. The key to the prevention of suicide is positive leadership and deep concern by supervisors of military personnel and civilian employees who are at increased risk of suicide.

(1) The tone which the unit sets allows the individual sailor or marine to know it is all right to have a problem and to talk about it. In those units which recognize all individuals get stuck from time to time and it is all right to ask for

assistance, the feelings of estrangement are reduced, adaption to change is enhanced and alternatives generated.

(2) Leaders and supervisors must know their subordinates and ensure timely assistance is provided when needed. Commanders must emphasize the importance of stress management and suicide prevention through the publication of command letters, unit general military and leadership training, unit instructions, and plan of the day notices, as appropriate. Inclusion of excerpts from enclosure (2) in the unit plan of the day is an excellent way to get the word out. Enclosure (4) lists points of contact for assistance.

(3) It must be recognized that, with some people, suicidal intent is very difficult to identify or predict, even for a mental health professional. Some suicides may occur even in units with the best leadership climate and most efficient intervention and suicide prevention programs.

b. Once identified as being at increased risk of suicidal behavior, military personnel, with or without their permission, will be referred to the appropriate medical treatment facility and tracked by the unit commander to ensure problem resolution.

c. Civilian employees identified to be at increased risk will be encouraged to seek assistance from appropriate civilian agencies. If there is reasonable concern that self-harm may be imminent then the situation should be immediately reported to the Installation Police Department and to a military or civilian physician or State mental health emergency worker. Enclosure (4) lists points of contact. Reference (d) provides police officers, acting under a physician's or State mental health emergency worker's advice, the authority to take into custody and to transport for evaluation, by ambulance or other suitable means, any person thought to be at risk for suicidal behavior.

d. Critical incidents, such as suicides or the accidental deaths of workmates, not only affect the victim and his/her family; they potentially affect all who knew the person or who were exposed to the event involving their death. To assist commands in coping with the predictable emotional upheaval in these stressing situations, command consultations and critical incident stress debriefings are available from the Naval Medical Clinic, Pearl Harbor per enclosure (3).

6. Assistance. Enclosure (4) lists applicable military and civilian points of contact. For further information regarding this instruction, contact Head, Mental Health Department, Makalapa Branch Naval Medical Clinic, 471-3393, or COMNAVBASE Pearl (N15), 474-4749.

W. W. RADICAN
Chief of Staff

Distribution:
COMNAVBASEPEARLINST 5605.1C
Case 1, Lists I - Shore Activities under "REGIONAL COORDINATION" of COMNAVBASE PEARL
II - Staff Offices
III - Other Commands
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Commander Naval Base
Box 110
Pearl Harbor, HI 96860-5020

UNDERSTANDING AND MANAGING SUICIDAL BEHAVIOR

1. The information in this enclosure is recommended for audiences at all levels and is intended to promote early intervention and reduce the risk of suicidal behavior.

2. Suicidal behavior is defined as any active behavior with intent to kill or harm oneself. This includes suicidal gestures (suicidal behavior with no serious consequences), attempts (suicidal behavior with serious or potentially serious consequences), and completed suicides. Suicidal ideation (thoughts) can escalate to suicidal behavior if not appropriately managed.

3. Statistics and Facts Associated with Suicide in the U.S. and in the Navy

a. Suicidal behavior is represented in all sectors of U.S. society, including the Navy; 12.1 out of 100,000 population commit suicide, 900 out of 100,000 population (.9%) attempt suicide and an estimated 10,000 out of 100,000 population (10%) have serious suicidal thoughts. The suicide rate in the Navy is approximately 11 out of 100,000 active duty population with the greatest number occurring in the 25-34 year-old age group. For the U.S., the suicide rate for the 25-34 year-old age group is approximately 16.3 per 100,000 population. For the same group in the Navy the rate is approximately 12.7 per 100,000 population. Rates of suicide in age-race matched males are lower in the military than in civilian communities. For females, however, the rates are higher.

b. Over the past three decades there has been no significant change in the rate of those who commit suicide (11-12 out of 100,000 population); however, during this period the suicidal rates of 15-24 year-olds has tripled. This age bracket constitutes the majority of manpower in the military. Nationally, suicide is the tenth leading cause of death. In persons 14 to 25 years of age, it is the third leading cause of death and, among college students, it is second.

c. Approximately 80% of all suicidal behavior is linked to substance abuse and addiction, primarily alcohol. By decreasing inhibition or impairing judgment, chemical intoxication may turn an ambivalently conceived gesture into a completed act.

d. A suicidal crisis, i.e., the wish to kill oneself, occurs only for a limited period of time (average 72 hours) but is subject to recurrence. Many suicides occur several weeks after apparent improvement.

e. Most suicidal persons have consulted a physician within 6 months preceding death; 10% have done so the week before committing suicide. A general physician sees an average of 6 seriously suicidal patients per year. Suicide prevention agencies see only 3-6% of those who kill themselves.

f. Men commit suicide three times as frequently as women and, women attempt suicide three times as frequently as men. Men use more lethal means than women.

g. Approximately 60% of all active duty suicides occur by gunshot and small arms.

h. Within the military there are two peaks of increased risk: within the first few months of service and within the last few years before retirement. The most common precipitant for suicide among Navy personnel is difficulty in a relationship (divorce, break-up, separation) or family problems. The second most common precipitant is difficulty on the job and with the Navy.

i. In the Navy 48% of suicides occur among E-5's and below. This group comprises only 33% of the Navy. Approximately 77% of suicide attempts, however, occur among paygrades E-1 to E-3, mostly within the first year of service.

4. Stress, Depression, Hopelessness, and Suicide

a. In trying to understand why people kill themselves, it is tempting to look only at the source of stress in their lives. While attention to stress management will have a positive impact on a person's mental health, stress alone does not cause suicide. Stress is a normal part of life. While people who commit suicide are particularly susceptible to stress, most people are capable of surviving stress through awareness and application of stress reduction strategies such as those suggested in enclosure (2).

b. Actually, most people <u>think</u> about suicide at some time during their lives. Usually they find these thoughts are temporary and that things do get better. Generally, it is a combination of events and reactions that lead a person to believe suicide is the <u>only</u> way out.

c. Depression is considered to be a contributing factor in most suicides. It is often confused with ordinary unhappiness. Sadness and an occasional "case of the blues" are normal emotions common to everyone. To be unhappy is to be sad or discontented when things go wrong; it does not involve a loss of perspective. Being depressed is a mood which affects the person's basic

emotional disposition, determining how people experience and perceive themselves and their surroundings. Symptoms of depression include:

(1) Poor appetite or significant weight loss or increased appetite or significant weight gain.

(2) Change in sleep habits, either excessive sleep or an inability to sleep.

(3) Behavioral agitation or a slowing of movement.

(4) Loss of interest or pleasure in usual activities or decreases in sexual drive.

(5) Loss of energy, fatigue.

(6) Complaints or evidence of diminished ability to think or concentrate.

(7) Feelings of worthlessness, self-reproach, or excessive guilt.

(8) Withdrawal from family and friends.

(9) Drastic mood swings.

(10) Sudden change in behavior.

d. Depression is essentially a reaction to stress. Hence, depression is a mood that can occur to anyone at any time. It is estimated that at least one half the adult U.S. population has been depressed at least one time or another. At any one time it is estimated at least nine million Americans are in need of professional help. The majority of these are not aware of their depression.

e. Depression can be viewed as an inevitable part of living. A series of major changes (e.g., promotion, marital separation, graduation of child in the home, financial loss) for better or worse, is apt to produce some degree of depression in most people. Change of any type, if it involves something or someone of importance to the individual, can be a catalyst for depression. The process of growing up and growing older involves a series of changes; every transitional phase of life, from childhood to marriage to old age, requires some degree of giving up, of letting go. In order to move successfully from one phase to the next the person must be able to experience depression in a

direct and meaningful way. However, when the symptoms listed above persist over a month, professional help is needed.

f. Considerable variation exists with regard to what degree people are susceptible to external influences. Some are highly sensitive to what goes on around them; others are not. For those who are, the environment can have a profound effect on mood. Their world may regularly confirm a healthy sense of self-esteem, allow for the expression of feelings, and provide them with an atmosphere of hope. On the other hand, if their environment provides no personal support, prevents them from becoming self-reliant, repeatedly stirs up hostility and at the same time blocks its release, provokes unnecessary guilt or causes them to feel lonely and rejected, a high incidence rate of depression can result.

g. Suicidal behavior typically becomes an option to a person when they perceive their predicament as hopeless and, in their eyes, the potential for being someone who matters has been exhausted. Hopelessness has been associated with higher levels of suicidal intent. High hopelessness during any one life experience may be predictive of higher hopelessness during a later episode and thus, may lead to eventual suicide.

h. Feelings of hopelessness and low self-esteem can have many causes:

(1) Break up of a close relationship with a loved one or difficulties in interpersonal relationships with family or close friends

(2) Death of a loved one, spouse, child, parent, sibling, friend, or pet

(3) Worry about job or school performance and concerns about failure or doing less well than one hoped or expected

(4) Loss of support systems or emotional safety which comes from moving to a new environment

(5) Loss of social or financial status

(6) The compounding and disorienting effects of drugs and/or alcohol

i. The problems of stress overload, depression, and hopelessness are temporary issues which can be overcome. Suicide, on the other hand, is a needless and permanent solution to these short-term problems.

5. Suicidal Behavior: Fables and Facts. Another way to look at the subject of suicide is to consider some common misconceptions:

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

Fact: Nearly 80% of those who attempt or commit suicide give some warning of their intentions. When someone talks about committing suicide, he or she may be giving a warning that should not be ignored.

Fable: Talking to someone about their suicidal feelings will cause them to commit suicide.

Fact: Asking someone about their suicidal feelings usually makes the person feel relieved that someone finally recognized their emotional pain, and they will feel safer talking about it.

Fable: All suicidal people want to die and there is nothing that can be done about it.

Fact: Most suicidal people are undecided about living or dying. They may gamble with death, leaving it to others to rescue them. Frequently they call for help before and after a suicide attempt.

Fable: Suicide is an act of impulse with no previous planning.

Fact: Most suicides are carefully planned and thought about for weeks.

Fable: Once a person is suicidal, he or she is suicidal forever.

Fact: Most suicidal people are that way for only a brief period in their lives. If the attempter receives the proper assistance and support, he or she will probably never be suicidal again. Only about 10 per cent of attempters later complete the act.

Fable: Improvement in a suicidal person means the danger is over.

Fact: Most suicides occur within about three months following the beginning of improvement, when the individual has the energy to act on his or her morbid thoughts and feelings. The desire to escape life may be so

great the idea of suicide represents relief from a hopeless situation. Often a period of calm may follow a decision to commit suicide.

Fable: Because it includes the holiday season, December has a high suicide rate.

Fact: Nationally, December has the lowest suicide rate of any month. During the holiday season, the depressed person feels some sort of belonging and feels things may get better. As spring comes and their depression does not lift, the comparison of the newness and rebirth of spring and their own situation can produce overt self-destructive behavior.

Fable: People seeing a mental health professional don't commit suicide.

Fact: People in the care of professionals do commit suicide. Never assume the person has divulged his or her suicidal feelings to the professional and is receiving proper attention. If the person seems suicidal, take action; don't assume it is under control.

6. High Risk Factors Associated with Suicidal Behavior:

a. Personal History:

(1) Previous suicidal behavior or wide mood swings

(2) Personality Disorder: borderline, immature (impulsive behavior), antisocial or compulsive

(3) Recent loss or anniversary of a major loss

(4) Living alone or not having close friends

(5) Unstable relationships: multiple, short-term or superficial

(6) Unexpected physical disability

b. Family History:

(1) Unstable childhood and adolescence: abuse, neglect or rejection

(2) Close relationship to someone who committed suicide

(3) Psychiatrically ill, self-absorbed or competitive spouse or parent

(4) Serious family discord or enmeshed family

(5) Lack of roots or contact with family

c. Educational and Vocational History:

(1) Unstable school, job or financial history

(2) Lack of extracurricular activities, hobbies

(3) Trouble with the authorities (past or present)

(4) Change of specialty/rate or college major three or more times.

(5) Disparity between aspirations and accomplishments

7. Early Signs (potential indicators of a person in distress):

a. Academic or Work Performance Reactions:

(1) Inability to concentrate or attend to details

(2) Confusion about duties and priorities

(3) Indecision, disorganization and procrastination

(4) Increased errors and decline in productivity

(5) Accident proneness

b. Physical Reactions:

(1) Muscle tension and tension headaches

(2) Fatigue and exhaustion

(3) Pounding or racing heart beats and increased blood pressure

(4) Shortness of breath, sighing or hyperventilation

(5) Increased perspiration

(6) Changes in digestive system function

(7) Decreased immunity to communicable diseases

(8) Insomnia or lack of sleep

(9) Slowed reaction

(10) Visits to sick bay with vague symptoms

c. Psychological and Behavioral Reactions:

(1) Frequent irritability, frustration, anger, explosiveness over minor incidents

(2) Impulsiveness, non-conformity or apathy

(3) Becoming very compulsive and rigid

(4) Anxiousness, panic, inappropriate emotionality when communicating

(5) Guilt, self-criticism and loss of confidence

(6) Feeling persecuted or preoccupation with unreasonable fears

(7) Forgetfulness and disorientation

(8) Misjudgment of people's motivation

(9) Desire to cry, run away or withdraw

(10) Denial of problems

(11) Not wanting to stop, slow down or take a breather

(12) Does not tolerate or accept praise

(13) Increased use of caffeine, nicotine, alcohol or drugs

(14) Neglect of healthy habits and hobbies

(15) Deterioration of financial state, accumulation of debts beyond means to pay

8. Late Signs (indicators of potentially imminent suicidal behavior) include the worsening of the above early signs and:

a. Talking about or hinting at suicide or homicide, making specific plans to commit suicide and to gain access to lethal means

b. Extreme alcohol and/or drug abuse

c. Obvious depression, despondency (feeling helpless, hopeless and worthless)

d. Disinterest and displeasure in previously enjoyable activities

e. Sudden euphoria or apathy without corresponding improvement in circumstances

f. Sudden generosity or giving away of valued possessions

g. Withdrawal from family and friends

h. Making arrangements as though for final departure: unexpected acquisition of a will, life insurance policy, talking to workmates as if he/she were saying goodbye

i. Obsession with death, sad music or sad poetry. Themes of death in letters or art work.

j. Defeatist and fatalistic statements: "You may be sorry when I'm gone." "No one cares or understands me." "I don't care if I die." "It's not worth it any more."

9. What To Do When You Suspect Someone is at Risk for Suicidal Behavior:

a. Take the situation seriously. It is easy to predict suicidal behavior when a person shows late signs as listed above. However, signs from many people are very subtle. You may have as little to go on as simply a disturbing feeling, or an overheard "Goodbye" instead of "Goodnight." Trust your intuition. The most important thing is to not ignore the issue. Remember the danger of embarrassment through overreaction is not nearly as great as the danger of death through failure to act.

b. Talk freely to the person about their thoughts and feelings. Remember most suicidal persons are ambivalent about suiciding and want to talk about it. You may discount your intuition and/or the seriousness of what you heard because the person "acted so casual" when talking about or alluding to suicide. Recognize this casualness for what it most probably represents: the person is acting casual for your benefit and is

trying to leave an opening for saying he wasn't serious, depending on your reaction. Once you are alerted to the clues that may constitute a "cry for help," you can help in several ways:

(1) Express your genuine concern by talking clearly and calmly about the situation. Share your objective observations and tell the person you are available and want to help.

(2) Ask about feelings/thoughts and inquire about their meanings. Ask specifically if the person is thinking about suicide. Your willingness to talk this way can be a big relief to the person, who probably feared you would be judgmental or would try to cut off communication and leave. Your acceptance may give him or her hope at a time when hope is exactly what is needed. Some examples of questions to ask:

(a) How long have you been feeling this way?

(b) Do you know why you feel this way?

(c) Have things gotten so bad that you are thinking about harming yourself?

(d) Have you thought about how you would end your life?

(e) Do you have a plan?

(3) Listen seriously and understand the problem. Avoid judgments in the process of responding to what you hear. People confronted by a suicide threat or similar statement often respond with something like, "Think how much better off you are than most people; you should be thankful for how lucky you are." This not only ends the conversation, it compounds the problem by potentially adding guilt. It is not helpful and may even be harmful.

(4) In addition to offering a sense of relief and hope, the questions you ask will yield information that will be valuable in helping a professional evaluate the seriousness of the suicide risk. In general, the more specific the thoughts and plans of suicide, the graver the risks. If a person has purchased a weapon with the specific intent of ending his life there can be little doubt of the seriousness and immediacy of the risk. If on the other hand, he or she has vague notions of ending his life but no concrete plan, the risk probably is not imminent. This distinction, however, is only a general principle. There are many variations and exceptions. So don't assume the risk is not great because the plan is not specific. That evaluation must be left up to a professional.

Enclosure (1)

(5) Some additional points to keep in mind:

(a) Do not avoid talking about suicide.

(b) Refrain from using simple advice or cliches.

(c) Do not analyze the person's motives.

(d) Do not argue or contradict.

(e) Do not try to shock or challenge.

(f) Do not agree to be sworn to secrecy.

(g) Confiscate weapons or other means of suicide if obtainable.

(6) Encourage positive action aimed at relieving the pain. Help the person come up with positive solutions. Solutions can include many possibilities including working to improve the home environment through couple or family therapy, developing more of a balance between work and recreation, a vigorous exercise program, new ways to relax, hobbies, sports, etc. The important points are that the person identifies it as something potentially useful to him or her and that it is possible to accomplish.

c. Seek professional help. No matter what else you do, or what your discussion leads to, or how much the person denies the intention to commit suicide or tries to assure you he or she wouldn't really go through with it, make sure he or she gets professional help. When the signs of suicide are there, professional help is needed. Encourage the person to get help. If he or she refuses, take the initiative yourself and tell the person what you plan to do. Explain the situation to his or her superiors if military, or explain the situation to a reliable family member. Consult with medical personnel for guidance.

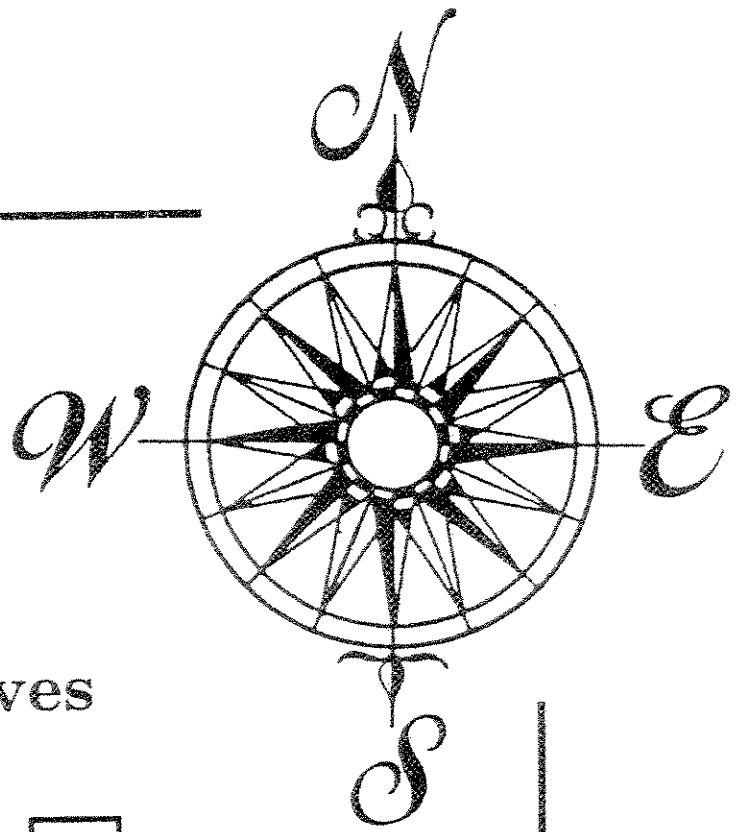
d. If the danger of suicide seems immediate, do not leave the person alone. Your presence may be the only thing preventing a tragedy.

10. Suicide prevention is not especially difficult to achieve. It requires the concern of a friend (or someone who cares enough to act as a friend), the knowledge to recognize the signs of danger, the willingness to talk openly and candidly, and the initiative to make sure professional help is obtained. More generally, it requires that old attitudes of treating suicide as

a taboo give way to an acceptance of suicide as a problem that can be dealt with frankly and openly.

11. Your knowledge of the few principles of suicide prevention presented in this enclosure, and your willingness to apply this knowledge might save someone's life. By sharing this knowledge with others, you might also break down some of the misconceptions and myths that have kept suicides from being prevented. The more people who understand and accept suicide for what it is - a needless and preventable cause of death - the greater the chance suicide will eventually be removed from the list of leading causes of death.

Enclosure (1)



Program Perspectives
on

SUICIDE PREVENTION:

GUIDELINES for Chaplains

DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF OF NAVAL OPERATIONS
WASHINGTON, DC 20350-2000

IN REPLY REFER TO
1734/9
Ser 971P/0444
23 MAY 1991

Dear Colleagues in Ministry,

This suicide awareness package provides guidelines you can use with a broad range of chaplain/command suicide prevention, intervention and after action initiatives. Practical ministerial ideas are provided and designed to assist you in dealing with this highly emotional issue.

The report "Program Perspectives" encourages chaplains to work with other command specialists in developing and maintaining suicide awareness programs which are suitable and acceptable for use in the sea service environment. It also includes working program models which you are encouraged to adapt to your own individual style of ministry and pastoral care.

As suicide continues to be a perplexing problem, all of us, if prepared, can be powerful allies of life to the person contemplating suicide. We will also be better prepared to minister to the family, friends and shipmates who are victimized by suicide, and to our commands who must face this issue. These resources are offered to bring understanding in this difficult area of ministry.

Sincerely,

Alvin B. Koeneman

ALVIN B. KOENEMAN
Rear Admiral, CHC, U.S. Navy
Chief of Chaplains

Leadership Guide for **Suicide Prevention**

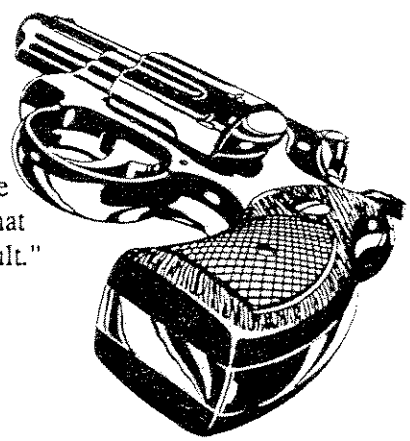
Suicide among young adults is a serious and growing problem. There has been a 300 percent increase in the adolescent suicide rate since 1962. More than 6,500 young Americans kill themselves each year. Taking all age groups into account, nearly 30,000 Americans die by their own hand each year. There are over 1,000 suicide attempts in the United States daily or one every minute of every day. Nationally, suicide is the tenth leading cause of death. These figures may in fact be higher as most researchers feel that many suicides are not reported as such.

This Division Officer's Guide to Suicide Prevention is designed to point out some features of suicidal ideation and methods for preventing suicide.

WHY SUICIDE?

There is no simple answer as to why people choose to kill themselves. Usually, the emotional upset is so great that the person "just wants to stop the pain." They feel helpless, hopeless, and worthless. Often they believe that it does not matter if they live or die and that no one would miss them. Suicidal people feel that they cannot cope with their problems and that suicide is the only possible way to escape unbearable pain.

Ray and Norbert, authors of ADOLESCENT SUICIDE, describe adolescence as a "Roller Coaster." They go on to say: "this period of growth, mentally, emotionally and socially is characterized by rapid change. It is the most intense phase of development, bringing more changes than at any other time in life. Actually, it is a time when too many changes are taking place too fast for some youths to cope. One of the biggest changes for adolescents is shedding the relatively comfortable role of a child for that of a responsible adult."



WHAT CAUSES SUICIDE?

In trying to understand why people kill themselves, it is tempting to look at the source of stress in their lives. An analysis of life stressors is not, however, the answer. Stress is a normal part of life and people are usually able to cope. Actually, most people think about suicide at some time doing their lives. Usually they find that things do get better.

Generally, it is a combination of events that lead a person to believe that suicide it the only way out. One common thread is that the person feels hopeless about life. Feelings of hopelessness and low self-esteem have many causes:

- Break up of a close relationship with a loved one or difficulties in interpersonal relationships with family or close friends.
- Death of a loved one: spouse, child, parent, sibling, friend or pet.
- Worry about job or school performance and concerns about failure or doing less than one hoped or expected.
- Loss of "support system" or "emotional safety" which comes from moving to a new environment.
- Loss of social or financial status of the family.
- The compounding and disorientation of drugs and/or alcohol.
- A feeling that there is no hope, no possible solution, no way that anything can be really "normal" again, no way to really love again, no way to succeed in life.

"A suicidal person is in a state of confusion and irrational thinking; he wants to continue his life but can't see the way."

WHAT ARE THE FACTS?

An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do or doing the wrong thing. However, just telling someone "I care about you" indicates there is hope and help. Misinformation often prevents potential helpers from becoming involved for fear of making the situation worse.

There are many myths about suicide which keep us from becoming involved. What are some these myths and what are the facts?

MYTH NO. 1: People who talk about suicide don't commit suicide.

WRONG. *DEAD WRONG.* Dr. Edwin Shneidman, this country's leading suicide expert, blasts this idea. He says, "The notion that people who talk about suicide don't do it is the most dangerous myth in the world. Four out of five suicide victims have made previous attempts. In every single instance, the person gives clues and warning signals that he is about to do it."

MYTH NO. 2: Suicide usually happens without warning.

NO! Suicides do not occur unpredictably. They are more often than not the result of long term inner struggle that is expressed outwardly in some clearly recognizable actions and attitudes.

MYTH NO. 3: Suicidal people can't be talked out of it. They are really intent on dying.

I quote again from Dr. Shneidman: "Nonsense! A suicidal person is in a state of confusion and irrational thinking; he wants to continue his

life but can't see the way. We find so frequently that lethal drives last just a short time so that if you can get him through the period of severe stress, his entire outlook can change and the very next day he may no longer be the slightest bit suicidal."

Nearly every suicidal person is torn between living and dying to such an extent that one authority says "the leap off a building may be the tragic result of a 51 to 49 internal vote."

MYTH NO. 4: **An individual's improvement following a suicidal crisis means the suicide risk is over.**

The person most likely to complete a suicide is one who failed in a previous attempt. Of all the signs, this one is the most foreboding. The Division Officer's role is this circumstance is to act, not assume. Saying "I thought he was getting better" won't bring the person back. Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.

MYTH NO. 5: **Suicide strikes more often among the rich -- or, conversely, it occurs almost exclusively among the poor.**

Suicide is neither the rich man's disease nor the poor man's curse. In fact, suicide is very democratic and includes a proportionate number of victims from all levels of society. Another says that "the average person who commits suicide is close to the average person."

MYTH NO. 6: **Suicide is hereditary; it runs in families.**

There is absolutely no evidence to suggest that suicidal tendencies are hereditary. When a family member takes his or her own life, it can prompt suicidal thoughts and even a suicide attempt among the survivors. This is especially true of a person already deeply troubled. But none of this has a thing to do with genetic factors.

MYTH NO. 7: **Someone who commits suicide is mentally ill.**

Studies of hundreds of genuine suicides indicate that, although the suicidal person is extremely unhappy, he is not necessarily mentally ill. Some very bright young sailors take their own lives because they no longer want to mask the secret torment that lurks inside. A prominent medical journal recently reported its findings that 12 percent of grade-school children, age six to twelve years, have had suicidal ideas or made suicidal threats. Are these children crazy? *NO.* Are they vulnerable? **You'd better believe they are.**

MYTH NO. 8: **Only certain people are the suicidal type.**

There is no such thing as a suicidal personality type. This menace touches every point in a cross section of society and is not limited to certain individuals with a certain make up.

MYTH NO. 9: **Most suicides are committed by older people with just a few years to live.**

FALSE. Persons over fifty are, statistically, less likely to take their lives. The most endangered group are those in the fifteen to twenty four year age bracket.

MYTH NO. 10: **Women threaten suicide, but men carry it out.**

This myth comes from a misinterpreted fact. Three times as many men as women commit suicide, but three times as many women as men attempt it. The explanation of this phenomenon lies in the suicide method. Women use less violent means such as pills or poison, increasing the

chance of rescue. Men are more likely to kill themselves violently with a gun, a knife, or a rope.

MYTH NO. 11: **Talking about suicide causes it by planting the idea in a person's head.**

NO. Talking about suicide will not cause suicide. Failing to talk about it may have disastrous consequences. You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true. Bringing up the subject of suicide and discussing it openly is one of the most helpful things a Division Officer can do.

MYTH NO. 12: **People who commit suicide are people who are unwilling to seek help.**

Studies of suicide victims have shown that more than half have sought medical help within six months before their deaths.

DEADLY GIVEAWAYS

1. WITHDRAWAL -- the sailor who pulls away.

To a certain extent, withdrawal is natural and good. But when withdrawal is severe, when there is obvious pulling away and into a shell, watch out. Unwillingness to communicate is perhaps the most common form of withdrawal, but there are other telltale indicators. Steady decline in professional performance, rejection of normally pleasurable activities such as sports or hobbies and an incessant desire to be alone can also spell a disaster in the making.

2. MOODINESS -- the sailor who's up and down.

Everybody is moody from time to time. We're all influenced by the weather, our health, our circumstances. Sailors are no different. But when there are wide shifts, up one day on the bottom the next, there is cause for alarm. There is ample evidence to conclude that many of our sailors have ridden an emotional roller coaster to death.

3. DEPRESSION -- the sailor who holds in.

Depression is a highly individualized experience. When they are depressed, some sailors become very sullen and totally wrapped up in themselves. They camouflage their feelings so well that no one is aware that anything is happening. In such cases, the only way to find out is by somehow getting the person to talk.

4. AGGRESSION -- the sailor who lashes out.

Many suicidal attempts are preceded by violent outbursts -- fighting, threats, cruel insults, even destruction of property. Frequently, acts of this nature are cries for help. But this kind of aggressive behavior, though usually out of character, often receives the opposite result: rejection rather than consideration. The sailor who wanted to be noticed is condemned instead.

5. ALCOHOL AND DRUG ABUSE -- the sailor who turns on.

Alcohol and drugs are always an escape, but especially for the sailor with life-ending thoughts. Sudden indulgence by a young sailor who hadn't previously gotten drunk or done drugs is a definite RED FLAG.

6. SEXUAL ACTIVITY -- the sailor who lets go.

Inappropriate sexual behavior sometimes reflects a desperate desire to relieve depression. By letting go completely with another person, the depressed sailor thinks satisfaction can finally be achieved. When there is no lasting satisfaction, suicidal thoughts can and do intensify.

7. EATING DISORDERS -- the sailor who punishes self.

Anorexia and bulimia are now two words well known by Americans. These frightful diseases have a strong connection to self-destructive thought and should always be considered potentially suicidal. Division Officers should watch for drastic weight loss. The celebrated case of Karen Carpenter, who died of an anorexia-induced heart attack, is a potent example of the risk. Hers was an unintentional suicide.

8. GIFT GIVING -- the sailor who gives up and gives away.

Some sailors who plan to take their lives will give away prized possessions to close friends or to others they wish were close friends. Suicide experts say this is an ominous action, a silver cloud with a very dark lining. It should prompt serious, concerned questioning.

9. TRAUMA -- the sailor who's been hit hard.

Each sailor has an emotional threshold, an internal breaking point. A major traumatic event or series of events can drive a sailor closer and closer to that edge. Leaving home and joining the Navy can seem like the end of the world to a young sailor who has built strong ties and sunk deep roots. The trauma of a divorce, a death, or an accident can hit a sailor hard, leaving him stunned, with thoughts of suicide running through the mind.

10. PERSONALITY CHANGE -- the sailor who is not the same.

Abrupt reversal is the thing to watch for. When a usually introverted person suddenly begins to act like an unbridled extrovert, joking and carrying on, it's not a laughing matter. Conversely, this holds true as well when the gregarious person becomes a loner. Personality change is also expressed in a lessened energy level, neglect of responsibility, or an I-don't-care attitude toward personal appearance.

11. THREAT -- the sailor who speaks out.

Any comment regarding the desire to die should be taken seriously. Some of the most common threats are "I wish I'd never been born" or "You're going to be sorry when I'm gone" or "I want to go to sleep and never wake up." These should be interpreted as seriously as "I'm going to kill myself."

Something like telling loved ones "good-bye" instead of "goodnight" may be the only clue.

Although this has been mentioned repeatedly, diligently watch for these signs. Don't feel helpless, because you're not. As a Division Officer you can help a suicidal person. You must communicate with the sailor, asking questions to probe the troubled individual's conscience. You must emphasize not being judgmental or harsh, but not being overly sympathetic either. And you must act.

WHAT TO DO

If you believe that someone may be suicidal, it is important to remember:

• Take threats seriously. Trust your suspicions. It is easy to predict suicidal behavior when a person shows most of the factors given above. However, the warning signs from many people are very subtle. Something like telling loved ones "good-bye" instead of "goodnight" may be the only clue. It's amazing the number of people who don't take death seriously! Domino and George, et. al., in their article entitled "Attitudes Towards Suicide" indicate that most people (50%) do not take threats seriously.

• Answer cries for help. Once you are alerted to the clues that may constitute a "cry for help" from someone in your division, you can help in several ways. The most important thing is not to ignore the issue. It is better to offer help early than to regret not doing so later. The first step is to offer support, understanding, and compassion, no matter what the problems may be. The suicidal person is hurting.

• Confront the problem. If you suspect that a person is suicidal, begin by asking questions. You may begin with a statement such as "You sure don't seem to have been yourself lately, shipmate." "You appear kinda down." " Is there something bothering you?" An affirmative answer to any of these might lead you to another question, such as, "Are you feeling kind of depressed?" An affirmative answer to this question might result in a question such as, "I guess sometimes it seems as though it's not worth it to go on struggling and fighting when so many disappointing things happen to you." An affirmative answer to that question might lead to, "Do you sometimes wake up in the morning and wish you didn't have to wake up, wish you were dead?" A "yes" might lead to, "Have you been thinking about killing yourself? Has suicide been on your mind?"

• Be Direct. Don't be afraid to discuss suicide with a person. Getting him to talk about it is a positive step. Be good listener. Don't make moral judgments, act shocked, or make light of the situation. Offering advice such as, "Be grateful for what you have," or "you're so much better off than most," may only deepen the sense of guilt the person probably already feels. Discussing it may help lead the person away from actually doing it by giving him the feeling that someone cares.

• Tell them you care. Sailors who attempt suicide most often feel alone, worthless and unloved. The Division Officer can help by letting that person know that you are always there for them to talk to. By assuring the sailor that some help is available, you are literally throwing him a life-line. Remember, although a sailor may think he wants to die, he has an innate will to live, and is more likely hoping to be rescued.

• Get professional help. The most useful thing the Division Officer can do is to encourage the sailor who is considering suicide to get professional help. If necessary, offer to go with them to take them to help. The Navy community offers many sources of help. Resources are listed on the next page.

WHAT NOT TO DO

- Don't leave anyone alone if you believe the risk of suicide is imminent.
- Don't assume the person isn't the suicidal type.
- Don't act shocked at what the person tells you.
- Don't debate the morality of self-destruction or talk about how it may hurt others. This may induce more guilt.
- Don't keep a deadly secret. Tell someone what you suspect.

RESOURCES
for Division Officers and Department Heads

Supervisors are not alone in assisting a shipmate or dependent. While you may be the first to recognize that there is a problem which may result in a suicide attempt, an entire network of Navy led support is available to help a member or dependent through the moment of crisis and to resolve the underlying problems.

Immediate crisis support is available from:

Command's Medical Office .....
Command's Chaplain's Office .....
Navy Family Services Center, 24-hour HOTLINE 444-NAVY
Naval Base Chaplain's Center 444-7361
Civilian 24-hour Suicide Crisis HOTLINE 399-6393

Post-crisis support is available from both military and civilian sources. The Navy Family Services Center interfaces with local medical, social, and legal service agencies and is a good place to start post-crisis support and problem resolution.

Important points of contact include:

NAVY FAMILY SERVICES CENTERS
- Norfolk 444-2102
- Little Creek 464-7563
- Oceana 433-2912

NAVAL MEDICAL CLINICS
- Sewells Point Clinic, Naval Base 444-2674
- Boone Clinic, Naval Amphibious Base 464-7858
- Oceana Clinic 433-2221

NAVAL HOSPITAL PORTSMOUTH
- Emergency Room 398-5064
- Department of Psychiatry 398-5270

NAVAL LEGAL SERVICE OFFICE, NORFOLK 444-4498
- Detachment, Oceana 433-3117

DRUG/ALCOHOL REHABILITATION CENTER 444-2191

Video Tape:

An excellent Navy-oriented suicide prevention tape with a somewhat misleading title, is available for use by commands. "Stress Management/High Blood Pressure--Living With Yourself," (#803505DN), is available for temporary loan from NETSCLANT, Bldg. W 313, at 444-4011 or 444-1468.

The position of leadership brings with it the responsibility for the safety of those we lead. This includes not only physical safety in the work environment; but, also, the mental well-being of the individual. When in doubt, ask for assistance; ignoring the signs of a shipmate's need may keep available resources from assisting when the need is greatest.

REMEMBER

Suicide is a traumatic event for the sailor and for all shipmates who have some connections with him or her. Edwin Shneidman, Ph.D., founding president of the American Association of Suicidology, has stated: **"Human understanding is the most effective weapon against suicide. The greatest need is to deepen the awareness and sensitivity of people to their fellow men."**

DEVELOPED BY

USS AMERICA'S Chaplains
and
Religious Program Specialists

ADDITIONAL INPUT FROM

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ADAPTED AND PRINTED BY

Navy Family Services Center, Norfolk

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PROGRAM PRESPECTIVES ON SUICIDE PREVENTION:
Guidelines for Chaplains
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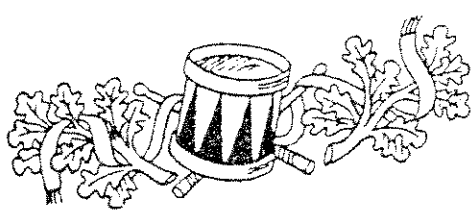
PART ONE – PROGRAM PERSPECTIVES

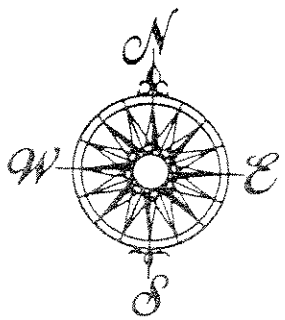
PART TWO – PROGRAM MODELS

PART THREE – ANNOTATED BIBLIOGRAPHY



OVERVIEW

Because our society tends to define suicide prevention as pulling a person away from an open window or talking them off a ledge, we may be resistent to recognizing the more subtle aspects of the issue. For all our task oriented desires to find and fix problems, suicide is one problem which has many converging, and often conflicting, circumstances. A person may have suicidal thoughts and not act upon them. On the other hand, while not planning to die but intending to draw attention to his or her unhappiness, an individual may, indeed, die of self inflicted wounds.

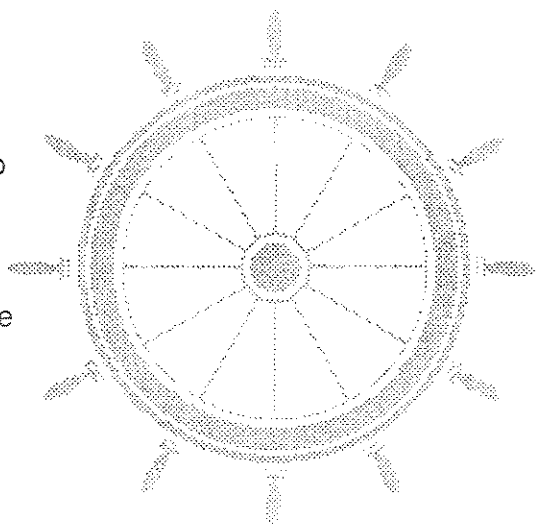


Suicide is a complex issue. There are divergent views regarding its cause. Depression, poor self esteem, loneliness, stress, isolation and loss of hope are part of a long list of symptoms, if not causes. One common observation regarding suicide is that there is no magic number of symptoms that suggest a person is in difficulty. Rather, it is the combined presence of symptoms that determine the potency of the problem. It is the duration, frequency and intensity of the symptoms that suggests the severity of risk for suicide.

Comprehensive suicide programs require not only prevention but also intervention and postvention as well. We must be ready to pull the person off the ledge; ready to intervene by offering assistance to persons experiencing thoughts of harming self; and, we must be ready to assist those who survive suicide. The primary goal is to prevent suicide. When that is not possible grief recovery and return to command readiness becomes primary. Family members need care in the aftermath. They often experience a sense of guilt and shame when their loved one commits suicide. Commands, too, will share similar kinds of family dynamics when a member dies by suicide and will also be in need of assistance in normalizing life.

For institutional settings such as military commands successful suicide prevention can begin with maintaining a well balanced selection of on-going programs designed to stabilize and enrich the lives of the service member and families. Although programs, of themselves, are not the only means of dealing with suicide, they are an excellent place to start. Because suicide involves not only the victim, but family members, shipmates, comrades, supervisors...buddies, a variety of programs can help increase the odds that service members and their families will find the help they need.

Because chaplains regularly relate with persons seeking assistance it is essential that they maintain awareness of the wide variety of on-going support services offered to personnel, and, in this instance, the specific suicide prevention services, which are made available to personnel and their families.



The chaplain can begin by assessing his or her own contributions to the total program. For example, consider the COMMAND RELIGIOUS PROGRAM. Do Planned Ministry Objectives reflect pastoral support in suicide related cases? How do area chaplain watchbills impact on follow-up of pastoral counseling for duty calls which involve suicide potential? Functioning in accordance with OPNAVINST 1730, the Command Chaplain's Office has responsibility for the following areas:

- pastoral counseling
- nurture/study groups
- pastoral care
- divine services

Cultivating other professional disciplines, the chaplain can maintain an awareness of other command sponsored activities. The MEDICAL TREATMENT FACILITY is one such activity. What are the MTF's requirements for timely referral of a member who is suicidal? What kind of follow up does the MTF provide to the service member/family and to the command? Be aware that, functioning in accordance with BUMEDINST 6520.1A, the following are among the MTF's responsibilities:

- suicide risk assessment
- medical/psychological treatment
- family advocacy treatment programs

Programs and services offered by the military FAMILY SERVICES CENTER are invaluable in focusing in on family and personal issues impacting on suicide among service members and their families. How does the center counsel and refer persons presenting with suicidal behavior or ideation? Is the command informed in order to ensure timely follow up support for the member? Following the guidance provided in OPNAVINST 1754, Navy Family Services Centers will often provide:

- counselors/social workers
- education and support group programs
- some centers have a crisis hotline

Alcohol is involved in a significant number of suicide attempts. Members of the command sponsored team of services, the COUNSELING AND ASSISTANCE CENTER (CAAC) and the Drug And Alcohol Program Representative (DAPA) may play a significant role in the suicide prevention program. What is the policy for referral of personnel considered to be at risk for suicide? Be aware of the functional responsibilities OPNAVINST 5350.4 assigns the CAAC in these areas:

- NADSAP (Navy Alcohol and Drug Safety Action Program)
- substance abuse evaluation and treatment referral

ON-GOING INITIATIVES

The command also provides for general and on-going concerns of members and families. Maintain an awareness of these concerns and how they are presented in program formats. Are the programs used by personnel? Do usage rates provide information on the value of such programs? And, most important, how often does the command religious program refer people to these activities as a source of personal growth? Areas of command concern include, but are not limited to:

- education and training/GMT
- leadership practices/unit cohesiveness
- physical fitness/sports recreation
- career/budget counseling
- sponsor/Ombudsman programs

For commands, one of the more troublesome aspects of suicide is the dynamic of isolation and shame the 'at-risk' individual often experiences. Offering support services in a positive atmosphere increases potential for identifying and dealing with persons who are at risk for suicide. Perceiving programs in terms of 'wellness' and 'enrichment' can do much to encourage persons to use those services – even before their situation reaches a crisis level.

Sometimes, it can be easier for the person to pick up a phone and talk to an anonymous voice over a receiver than to talk about their troubles with a buddy or a supervisor. In reality, many people have privacy issues in disclosing their personal problems to the command. In addition, do not underestimate the power of the 'it will hurt my career if I tell my troubles' stigma. Add to this the fact that the suicidal person feels isolated, often ashamed of their thoughts about ending their life and hopeless, helpless about changing their situation.

The chaplain can assist the command to 'take care of it's own' by capitalizing on a variety of services available to its personnel and families. Using community services should, in no way, compromise the command's opportunity to provide for its members. Myer Moldeven, in his article "SUICIDE: Prevention Must Be Everybody's Business," suggests an outline of ways to interface with community resources. Here are some ideas for adapting these suggestions:

- ❑ Routinely check with local crisis clinics in the area to determine the nature of distress calls being received from military people. Agencies guard this information very closely for obvious reasons of privacy. But, a command liaison can cultivate a professional relationship of trust between the agency and the command, as the command seeks only general information which they can evaluate to determine general trends. Names and individual problems are not needed in this case. The command chaplain or the CAAC representative are ideal liaisons.

- ❑ Provide information which will aid civilian professionals in understanding the military setting and system set up for handling suicidal service members and family members. Is the civilian agency aware of the emotional issues surrounding the cycle of deployments? Such general information need not be given in conjunction with deployment dates. And, when done on a somewhat routine basis, and in the spirit of community cooperation, these activities can also serve to foster a positive command image in the community.

- ❑ Ensure that key personnel such as security police, Master-at-Arms, Ombudsmen, family support workers are trained in recognizing the warning signs and how to refer potential suicides to professionals.

- ❑ If there are 24-hour hotlines in the community, ensure the phone number is posted around a central information bulletin board.

- ❑ Provide suicide prevention briefs for supervisory personnel in the command.

- ❑ Be supportive of TAD training opportunities for LPO level personnel in such services as Financial Counselor Training, Career Counselor Training, DAPA Training. Support the goals of the Command Assessment Team, which, by the way, is mandated in OPNAVINST 5354 to conduct an annual command survey which is designed to inform the command regarding human services agendas within the command.

STRESS AND SUICIDAL BEHAVIOR

There is debate among clinicians and behaviorists as to what extent stress impacts on suicidal behavior. Stress is a normal part of life; and people are usually able to cope. Experts do agree that stress can be a factor in the COMBINATION of events, situations, and decisions that lead a person to believe that suicide is the answer for them. Some observations regarding the unique stressors military members and their families experience can provide insight into how stress is a factor in suicide.

Stress can be as subtle as diminished work requirements which present low-demand stress associated with boredom. If the work schedule is cyclic, swinging from extremes of maximum to minimum output, stress can escalate. Repair and supply ships experience this kind of fluctuation, as do embarked Marine units. The alert chaplain will monitor responses of the troops during such fluctuations in the work load schedule. How well, or poorly, is the member coping with the changes in routine?

Stress impacts military marriages in unique ways. But for some couples stress can feed suicidal behavior by becoming part of a downward spiral into depression, isolation and a sense of hopelessness. For example, a service member may face a spouse who has increased hostility before and after deployment due to feelings of being deserted on departure and/or loss of independence upon the member's return. As a result suicidal behavior appears to increase prior to deployments. This is when collegial relationships with the medical treatment facility and civilian agencies can help the command evaluate the

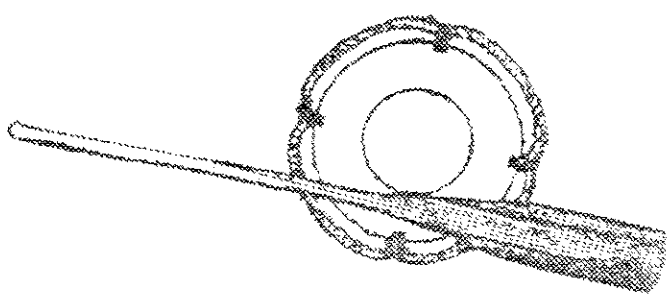
degree of manipulation present in the situation and determine strategies for managing the crisis.

Additional stressors include the first few months after enlistment and the last few years before retirement. These are life events in which one's self esteem and sense of belonging become vulnerable. Contributing factors range from the economics of changing from active duty to retired pay, to the simple activity of developing a new daily routine. For some, the change is not a welcome one.

In general, a program of stress management can help individuals discover positive ways of making stress work for them and not against them. Some medical treatment facilities and large shore-based commands having family services centers offer stress management programs. Such programs could even be offered on a squadron or unit level in much the same way an I-Division is offered. The most effective results occur when the program is designed to be:

- ❑ sensitive to the command's work schedule
- ❑ by referral from the member's command supervisor
- ❑ non-punitive for the member
- ❑ content specific with monitored attendance
- ❑ a standardized curriculum
- ❑ two mornings or one day
- ❑ offered routinely, perhaps quarterly.
- ❑ groups of 5 to 25 people.

Stress Management Programs can be set up in a variety of ways. The program coordinator may invite qualified speakers from several sources such as the Medical Training Facility, the Navy Family Services Center, or a civilian agency. Staff members of these agencies can speak on topics that lend themselves quite well to stress management. If the MTF has Psychiatrists onboard, a wealth of experience and information can be obtained from these physicians. Chaplains, by virtue of their religious tradition, have access to a rich and powerful perspective of spiritual meditation and personal reflection. Chaplains are in an ideal position to encourage individuals to use their own faith to engender and empower a sense of personal peace and harmony within themselves.



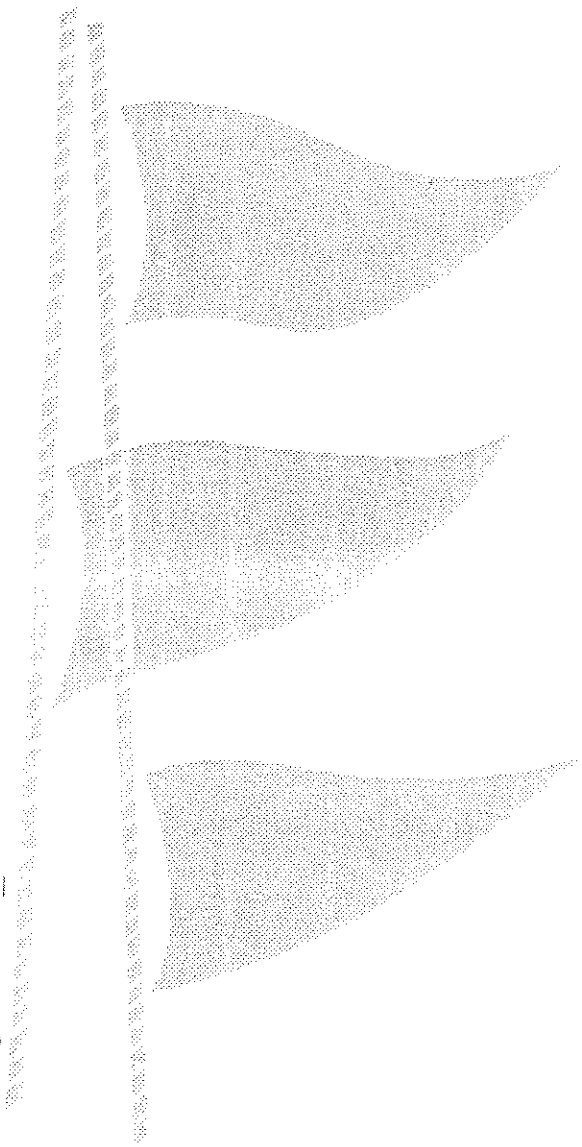
TRAINING AID SUGGESTIONS

Audiovisual media is the best way to communicate with today's young adults. Why not capitalize on it. Capture the military member's attention using a video as a teaching and training aid.

Preview the video. Avoid the frustration of having selected, ordered, gathered equipment and allotted an hour of time for a video tape which has bad sound, is Part Two instead of Part One, and doesn't have the impact message you had assumed. Use the preview session to determine if the video has a leader or discussion guide. Read the guide and use it in planning the training session. If there is no guide, create your own questions and discussion points while previewing the video.

Prior to the class session, make sure your equipment is set up and in working order. Preparing the space is important. If you are showing a video of quiet, contemplative music designed to help reduce stress, chairs may be in a semi-circle with space for extra room between rows. A video showing written data may require table top style student chairs designed for notetaking.

Anticipate possible audience response. It is possible that, as a result of having seen the video, someone will have an immediate emotional response which requires immediate pastoral, or medical, attention? Others may have a response that can be handled on an appointment basis. Is a referral system on line? After showing the video it is wise to have a plan of action already in place for immediate assistance, should the need arise.



Videotapes from a wide variety of commercal firms are available for lending, rental, or purchase. The Chaplain Resource Board maintains a lending library for active duty chaplains which presently contains videos on suicide prevention. Related videos on stress, problem-solving and self esteem are also available.

WHY DO I FEEL THIS WAY

Subject: People in crisis/depression, stressed or suicidal
Length: 50 minutes
Distributor: MTI Film and Video, Inc.
Format: VHS
Synopsis: Dr. Tim Johnson narrates this ABC special presentation. Three case studies are presented. They show persons under stress, who are depressed, who are having trouble coping with life. Identification and treatment procedures are discussed.
Use: Excellent refresher training for supervisory personnel who, having already attended suicide prevention training, would benefit from a view of the 'big picture' in assisting persons who are at risk.

PERFECT PEACE

Subject: Devotional; stress reduction
Length: 30 minutes
Distributor: Moody Videos; International Bible Society
Format: VHS
Synopsis: The gentle movement of the sun across the sky ...a summer rain...the rolling water through tree lined slopes of a mountain stream. These images together with the soft reassurances of God's Word and contemplative music create a sense of inner peace, trust in God's power and majesty. A visual encounter with peace and the Holy God in Jesus Christ, and the peaceful comfort of creation.
Use: Some sections are suitable as a "Call to Worship" or "Benediction" for Divine Services. Content is Christian; may be used in small group exercises, Bible Study or retreat programs.

THE WATERS OF MOUNT DESERT ISLAND

Subject: Stress reduction
Length: 30 minutes
Distributor: The Journal of Pastoral Care Publications
Format: VHS, S-VHS, 3/4" U-matic
Synopsis: Video photography from the Acadia National Park in Maine is woven together with an original piano score composed and performed in harmony with the natural sounds of the island to make this a very relaxing experience.
Use: A Leader's Guide provides instruction on educating viewers to maximize the effectiveness of the video. Content is ecumenical.

DESERT STORM: I WILL BE WITH YOU

Subject: Military member facing combat
Length: Nine songs; 3 - 5 minutes, each
Distributor: Time Well Spent, PO Box 2000, Laguna Hills, CA. 92654
Format: Audio cassette
Synopsis: Though it is designed specifically for personnel in the Gulf War of 1990-91, the content is timeless for people facing the possibility of armed struggle. Certain selections and dialogue speak to issues of loneliness and anxiety in general. Narrator speaks to military members stationed in the Persian Gulf theater of operations, Winter, 1991. Offering assurance of God's loving care and encouraging the member to have courage the narrator speaks about the warrior/prophet David as an example of faith and courage between contemporary religious songs such as, "I Will Be With You,", "You Are My Refuge," "The Lord Is My Light," and "The Lord's Prayer," and more.
Use: In small group settings selections may be played for group discussion. Some sections are suitable as a "Call to Worship" or "Benediction" at Divine Services.

IN SUMMARY

Of course, there are additional issues in suicide prevention, intervention and postvention. The books, periodicals and audiovisuals listed in the Annotated Bibliography of this booklet reference some of these issues. The bibliography references a variety of resources: parent's perspectives on suicide; prayers which may be used at a funeral service; a video package on mental fitness which includes a leader's guide and student workbooks; Channing L. Bete's video package on stress management containing booklets, handouts and a well designed video presentation; pastoral care and counseling texts, and more.

The examples of suicide prevention briefs and the Memorial Service included in this booklet can also assist you in creating programs which fit the needs of your command and community. Use this information to gain further insight into ministering to persons in the sea services.

Because there is no one thing, no panacea, which will eradicate the act of taking one's own life we must work together to do what we can, when and where we can. Then, we must trust the Great Creator to use our actions for the ultimate good of all.

SUICIDE: RECOGNIZING THE WARNING SIGNS

Brief delivered to Marine Corps non-commissioned officers, Camp Elmore, Norfolk, VA.

by Julia T. Cadenhead, LCDR, CHC, USN

I am going to speak to you this morning on how you can learn to recognize the warning signs that indicate an individual may be suicidal. It is a difficult subject for most of us. We tend to measure success in terms of having pulled a person away from a window or talked them back off a ledge. We do not always recognize success as simply getting in individual to a professional counselor BEFORE a gesture is made. Maybe that is why the suicide rate is so high? 35,000 Americans kill themselves each year - 95 people per day are dying by their own hand. We need to learn to spot people who demonstrate the warning signs and get them some help BEFORE they attempt to kill themselves. Once they make that first gesture, that first attempt on their life, the risk is greater that they will succeed the next time.

Let's talk about PREVENTION. How can you tell if someone is suicidal? And, what do you do about it?

First of all, get to know your troops. You are in a position to either know yourself or have access to middle management who knows them. You need some knowledge of what their normal/routine behavior is. Doing this will, also minimize the "con" factor which I will address later on.

Do a risk assessment. What is that? Risk assessment is basically asking a series of questions about the individual. There are certain symptoms affecting the individual's physical, emotional and behavioral state that will give you some important clues as to what extent he or she is "at risk".

Check out the person's background: Is there any drug or alcohol abuse? By "abuse", I mean, "Does he/she drink a lot, and routinely?" Has a close friend or family member ever committed suicide? (This is an often overlooked clue which is highly significant.) Has the individual attempted suicide before? Has the individual suffered a significant loss: divorce, financial problems, a child who is very ill, death in the family, etc.?

Check out the individual's behavior: Is he depressed? Does he have difficulty sleeping? Has he lost his appetite? Have there been any BIG changes in his behavior? (Once out-going and friendly, has he suddenly become somber and stand-offish? Has he gone from no energy to being hyperactive?) Does he have difficulty staying with the conversation; that is, in concentrating on what is going on? Is he preoccupied with death or violence?

The more "yes" answers to these questions, the greater the risk the individual may act on what he or she says. In other words, if the individual has several of these symptoms present in his or her life, PAY ATTENTION to him or her; to their conversations. If she says,

"I'd be better off dead", or

"Why doesn't somebody just kick me in the head and let me die."

Then, in a calm and even-toned manner, confront her. Usually, repeating the statement back to the individual in the form of a question is effective.

"You'd be better off dead?"or

"What does ' I can't take it anymore ' mean to you?"
Imagine... shipboard, you are the chief of the watch in the pilot house. The officer of the deck says,

"Sound general quarters".

(You say) "Sound general quarters, aye".
Then, you do it. That is clarification to make sure things are done right. Same idea here.

"You said you would be "better off dead"...?"

There is a particular behavior I would like to speak about. It is one of those questions you need to check out. Is the individual accident prone? Is she the "company clown"? Is he a "thrill seeker"? This kind of behavior can be very hard to analyze because of the nature of the mission of The Corps. You work with weapons all the time; you are trained to fight; you are trained to complete a mission of probable violence. A thrill seeker may be hard to spot in your ranks. Let me clarify: I do not mean the individual who moonlights as a comedian at the dinner theater on weekends. I do not mean the individual whose personality gives him a loud, rough-housing style. I am talking about the individual who goes just a little bit too far; just a little bit overboard. Maybe he just kind of "grates" on your sensibilities. Watch out for this individual. Are there 'yes' answers to other problems in his life? Listen to him. Ask him questions. That person just may be in trouble with himself.

Let me explain further: There are times when you are called upon to be "super human". You know, force recon training... Sometimes, being tough is the only way to survive. But, WATCH for the individual who is your "habitual Rambo". This kind of person has a lot to lose, what if he wants to cry when his wife leaves him? He can get trapped between his "I'm Bad" image and his marriage. At that point, he has no alternative for feeling good about himself. He may experience something like this:

"I'm not tough like I thought I was, I'm crying/feeling like I can't make it without her."
He loses face with himself. BOOM, what else is there...

"Maybe I can't make it..." he thinks.
Maybe he WILL NOT make it.

What if she wants to go see her folks for the weekend but the company wants to par-tay? She wants to belong; to prove she's as hearty as the next Marine. She stands to lose her self esteem if she doesn't go.

"I'd rather go see Mama; maybe I am a wimp", she thinks.

"Maybe I can't take life in the fast lane?"
Maybe she won't.

We all have times when we face situations we can't change. At some point in our lives we all find ourselves helpless in the face of bad news; disappointed about a new duty assignment. Some people can get caught in a downward spiral. I mean something like this:

What about the Marine who kicked at a land mine out in the field? What about the buddies who ragged him saying,

"Don't do that kinda stuff, man!"
What about that Marine when he kicked a second land mine that day, just minutes after his buddies had told him not to? What about that Marine's death when that second mine when off killing him and injuring his buddies? What about his recent depression over a failing marriage? Was he suicidal? Who knows. Maybe. Wonder what combination of symptoms were present in that Marine's life that were affecting him that day? One thing is for certain:

weapons and 'at risk' individuals do not go together. Do not LET them: one of the first rules of prevention is to remove the means by which an individual can/or has planned to kill himself. The life you save may be your own!

There are also some readily identifiable events in military life which can fuel suicidal thought/gestures: among them are readying for contingency operations and the last few weeks out on deployment. These are occasions when people may begin to feel hopeless...

"What makes me think things are gonna be any better when I get back..?"

A Marine may be getting heat at home about her long working hours. She's embarrassed and doesn't tell anyone in the company. She doesn't go to anyone for help; keeps it bottled up; isolates herself. Maybe a few beers will ease the pain, she thinks. And, then, the company gets word of a major deployment. Stress escalates; she sees no may out of her problem between work and her family. Drinking escalates, performance marks suffer because she's coming to work late. The downward spiral begins...

Also, recent studies about suicides indicate that holidays are not necessarily 'high risk' periods. Actually, it is the quiet, colorless, let-down days following the holiday season that can be danger periods. Life gets back to the old routine. People may begin to feel hopeless and helpless again. It can be easy for them to perceive that things are still as bad as they were before the holidays. In order words, easy for them to feel that life is hopeless and will never change for the better.

Now, to speak about an especially difficult issue, you, as people managers must face: the issue of being "conned." No one likes to be "conned" It is humiliating. A prevailing concern is

"If we educated everybody on the warning signs of suicidal behavior, they will try to imitate the symptoms in order to get out of something!"

Remember two things: First, health care professionals agree that there seem to be 'active periods' when they see more 'at risk' of committing suicide. And there is evidence that teenagers seem to be part of a phenomena called 'cluster suicides'. So, it is possible that you may have more than one person who has suicidal thoughts at certain times. BUT, and this is the second thing, if you have strong reason to believe you are being 'conned', BACK OFF AND CONSULT. RE-GROUP. Lead by management. That is, send the individual over to see the career counselor; send him to medical for a check up, get the individual over to see the chaplain...check rumor control. Take a look-see at her Service Record. Get input from others. Use teamwork. I suppose you could call it CYA, but more significantly, it is doing what you are trained to do - take care of your own; use the system to do it. Spending an hour or two of work time in medical or the Chaplain's Office is well invested if it can mean avoiding an all day funeral detail.

Identifying individuals who are at risk for committing suicide requires the concern of a friend; the knowledge to recognize the symptoms of danger, the willingness to talk openly, and the initiative to see that professional help is obtained. Marines, you have that very special quality of "esprit de corps." Use it to take care of each other !

SUICIDE
IN THE
NAVY
(What Can I Do?)

The Problem...

- inappropriate behavior diminishes effectiveness
- any death, espec suicide, induces command trauma

SUICIDE
FACTS and
A
B
L
E
S

SUICIDE HAPPENS
WITHOUT
WARNING

FACT OR FABLE ?

SUICIDAL PEOPLE
ARE FULLY INTENT
ON
DYING

FACT OR FABLE ?

PEOPLE WHO TALK
ABOUT SUICIDE
DON'T COMMIT
SUICIDE

FACT OR FABLE ?

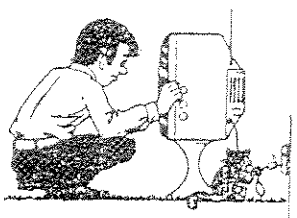
IMPROVEMENT
AFTER A CRISIS
MEANS THE
RISK
IS OVER

FACT OR FABLE ?

SYMPTOMS

CHANGES
behavior
eating
sleeping

prior try
alcohol
final arrangements
pressure/stress

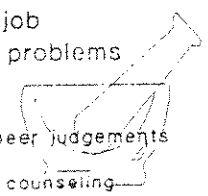


REFER
Don't keep
deadly secrets !

DOCTOR
CHAPLAIN
DIVISION OFFICER
CAREER
COUNSELOR
FAMILY SERVICES

POST VENTION

PUT BACK TO WORK:
- right job
- some problems



- reduce peer judgements
- listen
- continue counseling

YOU CAN.

WE CAN.

SUICIDE ABATEMENT LECTURE WITH SLIDE PRESENTATION

by Victor Smith, CAPT, CHC, USN

Materials needed: Overhead projector; transparencies (or slides); VCR and monitor; videotape chosen by presenter; handouts; meeting space.

FORMAT

I. LECTURE using overhead/slides, 20 minutes
II. VIDEO showing, 30 minutes
III. WRAP UP dialogue, 10 minutes

LECTURE OUTLINE

I. Using question and audience answers style as much as possible, ask

"Who has had an experience with a suicidal person?"
"What happened?"
"How did you feel?"
"Still hurts...?"

- ❑ Commands as messed up, too, by death. Suicides are often more difficult because the reason for the death seems obscured. Even when a shipmate gets run over by a tractor trailer, the command is affeced. The reaction is sometimes worse when the reasons are less apparent.

- ❑ What may be contributing factors to the Navy rate being lower than civilian counterparts? (e.g., shipmates are closer and see changes in behavior sooner).

- ❑ One reason we are concerned is that ANY death is too many. We can make a dent in the numbers and save some of our shipmates by paying attention to them. If an enemy had a gun pointed at your cohort, you would disable the enemy rather than let your cohort be shot. Same with suicide signs.

- ❑ Let me ask you about some often quoted statements about suicide. (use "Fact or Fiction" transparencies/slides)

- ❑ "There is a Tom and Jerry cartoon that I remember when growing up. The mouse was bored one day; a little fellow popped up on his shoulder with a pitchfork and a long tail who whispered in the mouse's ear to pull the cat's tail. Another little fellow popped up on his other shoulder with a halo and wings who said that would get him in trouble. An argument followed, and the one with the pitchfork threw it at the one with the halo, who then disappeared. This argument obviously was going on inside the mouse who was thinking about both things at once. You may be thinking about last summer's vacation, or home, or anything, while listening to me talking (which

you are being paid to do). There is evidence that suicidal people have a battle going on inside themselves. If you have a chance to save a life, which shoulder are you going to stand on? That is, which side of the argument do you want to take?

- ❑ The great fear is that talking will put ideas in the other person's head. If you have already asked, and the other person has already admitted to thoughts, you can't plant something that is already there, and talking can help the other put things into perspective. It also helps you discern what level of danger the person is facing. The higher the danger, the more definite the plans, the more important it is to seek help. If the person is in possession of the intended lethal weapon, take it away and do not leave the person alone until you have him/her in the hospital ward.

- ❑ When a person thinks the circumstances are similar or the closeness of relationship links with the one who has committed suicide, suicide may seem more of an option. Hence the 'pact' or contagion effect among adolescents in schools.

- ❑ Doctors feel that if behavior patterns are not changed, decisions causing frustrations may resurrect the old solution (of thinking about suicide) for people who may have felt suicidal in the past.

- ❑ What warning signs might one detect from a person with suicidal thoughts? There are others than those listed. Sometimes a gut feeling is enough.

II. Let's watch the VIDEO then come back to the symptoms.

- ❑ (After the video) ask,
  "What do you do if you see a shipmate who you think might be in danger?"

"In the Navy structure, who can help?"
" 'Postvention' is a ten-cent word meaning 'afterwards'. What do you do?"

Usually in a prior answer, someone has said that the root problems need to be addressed This is one vehicle which supervisors can frequently influence: "wrong job" dilemma - sometimes the Navy cannot respond to people being in the wrong job so listening and letting the person vent is sometimes enough; "problems at home" dilemma - a person may need to be directed to family counseling and given time to make the sessions; a person may need to be referred to CAAC for evaluation for alcohol abuse.

III. WRAP UP. Provide a handout which lists warning signs and location/phone of local suicide counseling agencies. Go over the warning signs with the class.

- ❑ Delay in leaving the meeting space and be aware of the audience as they leave: does anyone appear to be in stress, anyone have a need to speak with you. It may be time to refer, or to act, on behalf of one of the persons in the audience.

POSTVENTION – Psychological Aid For Survivors*

by Lt. Thomas W.S. Logan, Jr. There is Hope: Chaplain's Manual for Suicide Prevention. Commander Submarine Squadron Two, NAVSUBASE New London, Groton, CT.

Often the Chaplain will have a short time to work with the survivors. He/she may only have the opportunity for one visit. There is not enough time to provide in-depth assistance. There are some helps the Chaplain can give them in a short period of time. Here are some suggestions.

1. Visit the survivors within 72 hours of the suicide. During the visit initiate conversation about the suicide and let them know that their grief is different from other deaths through natural causes. Do not be afraid to use the word suicide. Doing so helps them face the reality of what happened. Encourage the family to have a personalized funeral or memorial service and to attend the command sponsored memorial service. Strongly recommend not to try to "hush it up," though they may be uncomfortable about the suicide.

2. Do not say "I understand." Surviving families will not believe you unless you are a survivor of suicide yourself. You should listen to them without being judgmental. Listening conveys to them that you do not see them as terrible people which they may feel they are.

3. Let the survivors know that although they may feel guilty, the death was not their fault. They did not make the choice.

4. With the immediate family, share any information about other suicides in the civilian community, or in your personal life. Survivors may feel less shame when reminded they are not the only ones to have this experience.

5. Provide literature about suicide and grief.

6. Inform the survivors of the major stresses they might experience. Tell them about the various reactions to suicide, both individual and family reactions. Encourage them to be kind to themselves, to accept their grief, and to be patient with themselves. Urge them to take care of themselves physically, to eat well, and to get plenty of sleep.

7. Respond to the survivor's question "Why" by focusing on the underlying issues:

- What was there in my loved one's life that made it so unbearable?
- Was I partly responsible
- What could I have done to make him/her happier?
- Could I have kept him/her from dying?

Guilt is the underlying issue the survivor is dealing with in pursuing the answer to the question "Why." They will ask this question repeatedly. Suicide is a very complex issue and the answer to this question can never fully be given.

8. After a suicide, survivors may feel everything is out of control. Encourage them to reestablish daily routine so they can begin to feel a little more in control.

9. Provide information about survivors' support groups and encourage them to get involved even if the survivors move.

10. Support any religious conviction that the survivor may have. Tell them it is all right to be angry with God. Reassure the survivors that if their faith is shaken that this does not mean

they are a bad or sinful person. Help them to recognize they are filtering everything through their emotions.

11. Share with them that the grieving process may take a long time. Sometimes, it may be a year before grief is worked through and it sometimes takes a lot longer.

12. Most of all, tell them they need to express their emotions. Encourage them to talk to someone. Urge them not to keep their emotions bottled up inside them.

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* Adapted From:

Earl A. Grollman, *Suicide Prevention, Intervention, Postvention*. Beacon Press, Boston, MA 1988, pp. 98-99.

Bill Steele and Mary Leonhardi, Survivors: *What to do When There Has Been a Suicide*. Ann Arbor Publications, Inc., Naples, FL, 1986, pp. 72-76.

ANNOTATED BIBLIOGRAPHY

David R. Allen, Ph.D., "Never Surrender". PO Box 1041. Indiana, PA. 15701

Dr. Allen has created a business-card sized piece called "NEVER SURRENDER". The title taken from a popular song of the same title by singer Corey Hart. The card includes: teenage suicide myths and facts, warning signs, how one can help a friend who is hurting, what to do if you're the one who's hurting, and space for schools and other organizations to print the locations and telephone numbers of groups teenagers can call for help. Contact Dr. Allen at the above address to find out how to order quantities of the card.

Timmon L. Cermak, M.D. Diagnosing and Treating CO-DEPENDENCE. Johnson Institute Books. 7151 Metro Blvd. Minneapolis, Minn. 1986.

When describing co-dependent variants, the author describes the person he calls the 'apathetic co-dependent'. This type person, he says, sinks into an emotional stupor in which life looses any sense of hope or meaning in living. "They may take their own lives actively and directly, or passively and indirectly - by doing nothing to avoid an accident, for example, or by refusing to see a doctor at the onset of disease."

Corinne Chilstrom, M.Div. "Suicide and Pastoral Care". The Journal of Pastoral Care. Fall 1989, Vol. XLIII. No. 3 pgs. 199 - 208.

Drawing on her personal experience as the mother of an 18 year old son who committed suicide, the author reflects on the many dimensions of suicide: various types and reasons for suicide, and the variety of reactions by suicide survivors. Noting the stigma of suicide, the author views this compounded grief as one requiring wise and sensitive pastoral care. Eloquent, succinct, and easy to read, this article provides excellent insight into the pastoral care needs of family members who have lost a loved one to suicide.

James T. Clemmons. "What Does the Bible Say About Suicide?". Minneapolis: Fortress Press, 1990.

The author, Professor of New Testament at Wesley Theological Seminary, Washington, D.C., looks at the biblical literature from the Hebrew scriptures to early Christian literature. He examines suicidal behavior, self-sacrifice, and martyrdom in light of scripture.

Frank Colquhoun, ed. Prayers for Every/All Occasion. Morehouse-Barlow Co. Wilton, CT. 1967. p. 245.

The author provides "Prayers Which May Be Used at the Burial of One Who Has Taken His Own Life."

Dr. Paul DeBlassie, III. Inner Calm. Ligouri Publications. One Ligouri Drive. Ligouri, MO. 1990.

Subtitled "A Christian Answer to Modern Stress", this book is designed to help people heal themselves from the ravages of modern day stress. Dr. DeBlassie, from the Christian Psychological Center in Albuquerque, New Mexico, leads readers on to deeper spiritual experience by use of the time-honored Jesus Prayer.

Center of Disease Control "CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters" Morbidity And Mortality Weekly Report. Atlanta, GA:

Epidemiology Program Office, Centers for Disease Control Atlanta, US Department of Health and Human Services. August, 1988.

This "how-to" booklet outlines and discusses recommended community actions for dealing with further suicides or suicide attempts within a targeted grouping. It speaks to issues such as how sensationalized information about suicides that have occurred can contribute to 'contagion' of the act. It addresses elements in the environment that might increase the likelihood of further suicides or suicide attempts. The conditions required for a good response plan to suicide in the community are discussed.

Edward J. Dunne and John L. McIntosh and Karen Dunne-Maxim. Suicide and Its Aftermath: Understanding and Counseling the Survivors. W.W. Norton & Co. New York, N.Y. 1987.

The authors provide an in depth study of family members, close friends and others who experience the loss of a loved one through suicide. Counseling strategies are discussed.

Great Performance, Inc. Stress Management. 14964 N.W. Greenbrier Pkwy. Beaverton, OR. Training Images International. 22804 Victory Blvd. #155. Woodland Hills, CA. (Distributor). Ask for "Leslee". 800-882-9436.

This 16-page booklet written in a workbook format teaches four sets of skills for managing stress: awareness, acceptance, coping and action.

Sidney Goldstein. Suicide In Rabbinic Literature. Hoboken, N.J. KTAV Publishing House, Inc. 1989.

In this book, Rabbi Goldstein examines the approaches adopted by Jewish halakhists and thinkers over the centuries, comparing them to classical and Christian attitudes regarding suicide. Rabbi Goldstein's concern for the applicability of the relevant laws and opinions to modern problems is evident throughout the study. Topics of note include: suicide and the consumption of alcohol; suicide as an act of martyrdom; suicide under conditions of incarceration; humiliation as a cause of suicide.

Corrine L. Hatton and Leonhardi. "Bereavement Group for Parents Who Suffer a Suicidal Loss of a Child". Suicide and Life-Threatening Behavior. Vol. 11. No. 3. Fall. 1981.

J.C. Helmkamp. "A Descriptive Summary of Active-Duty Deaths in the U.S. Navy in 1986". Military Medicine. 153: 621-625. 1988.

John H. Hewett. After Suicide. Westminster Press. Philadelphia, PA. 1980. pgs 113 - 116

The author has developed a memorial service to be used by family on the anniversary of a suicide.

Polly Joan. Preventing Teenage Suicide. Human Sciences Press, Inc. 72 Fifth Avenue. New York, N.Y. 1986.

This 147 page book presents a program model for guiding adolescents in ways to understand and cope with depression and/or suicidal feelings. In addition to identifying the classic warning signs, the author also addresses such issues as what to do when you're depressed; role plays of crisis counseling situations; and, listening awareness activities.

Pat King. Scripture-Based Solutions to HANDLING STRESS. Ligouri Publications. One Ligouri Drive. Ligouri, MO. 1990.

This unique book provides a practical, hands-on approach to stress management. The author, mother of ten, writer and speaker, combines scriptural advice, professional research and her own experiences. She creates a workbook approach to conquering energy depleting stresses. There are twelve lessons which include exercises, prayer and journalling activities which are designed for individual or group use.

Jacques Pohier and Dietmar Mieth, Editors. Suicide And The Right To Die. Stiching Concilium and T. & T. Clark, Ltd. Edinburgh. 1985.

This is a collection of essays by philosophers, psychiatrists and Roman Catholic theologians from all over the world. In the area of theology, the traditional moral stance of the Roman Catholic Church is presented and discussed, along with funeral rights and liturgical developments. The application to ministry extends beyond the specific context of suicide as violent self-injury, and into medical ethical decisions regarding euthanasia.

Robert D. O'Rourke. Prescriptions For Stress. Allen, Texas. Argus Communications, Inc. 1982.

This collection of a wide variety of positive coping behaviors is not a stress 'theory' book. The author recognizes that we can never eliminate stress from our lives. Therefore, this stress management book contains practical, down-to-earth methods for becoming more confident in dealing with pressure and anxiety. Among the more than 35 suggested exercises is: "A Rosary of Pleasant Memories", "Mantra for Peace of Mind', "Gone Fishin' ", "Give Yourself Away', "Pitching Horseshoes", and "Advice for the Middle Years."

Alan McEvoy and Edsel L. Erickson. Youth and Exploitation: A Process Leading to Running Away, Violence, Substance Abuse and Suicide. Learning Publications, Inc. P.O. Box 1326. Holmes Beach, Fla. 34218

The authors discuss the character of exploitation in the intimate relationships of family and so-called friends of adolescents and how this impacts on young people who are at the point of suicide, drug abuse, running away or violence. Concluding chapters include information on risk reduction, resources and recommended readings.

Merrill F. Baver, M.S.W. Ph.D. and George Dyck, M.D. Mental Fitness: A Guide to Emotional Health. Crisp Publications. Los Altos, CA. Training Images International (Distributor). 22804 Victory Blvd. #155. Woodland Hills, CA. 800-882-9436, ask for "Leslee".

This 63-page paperback book is written in workbook format. The book's objective is to help a person develop a personal action plan to improve the quality of his or her emotional health; and then make any required behavioral changes by applying concepts presented in this book to that person's unique situation. It can be used for individual study, workshops and seminars or informal study groups. There is a video package available: VHS video, five books and a Leader's Guide.

Dick Schaeffer, Pamela Espeland, Editor. Choices and Consequences. Johnson Institute Books. Minneapolis, Minn. 1987.

The subtitle of the book, "What to do When a Teenager Uses Alcohol/Drugs", provides a step-by-step system of intervention with teenage substance abusers. Pages 21 - 26 and 40 - 43 reference suicide plans and attempts and how suicide relates to the abuse process.

Judie Smith Suicide Prevention: A Crisis Intervention Curriculum for Teenagers and Young Adults. Learning Publications, Inc. P.O. Box 1326 Holmes Beach, Fla. 34218.

This 65-page workbook, including fill-in-the-blank sections, is designed to be used as five separate lesson plans. Practical, hands-on information and education on such topics as identifying feelings and empathic responses; an open-ended statements exercise on attitudes about suicide and a suicide questionnaire. Workbook goals include helping the student become aware of their own attitudes about suicide, become knowledgeable about the problem of suicide, acquire listening and communication skills, and learn the principles of suicide prevention.

Carol Staudacher. Beyond Grief: A Guide for Recovering From the Death of a Loved One. Oakland, CA. 1987.

R. Scott Sullender, Ph.D. and H. Newton Malony, Ph.D. "Should Clergy Counsel Suicidal Persons?". The Journal of Pastoral Care. Fall 1990. Vol. XLIV. No. 3. pgs. 203 - 211.

In this discussion of the issues involved in the pastoral counseling of suicidal persons in light of the Nally vs. Grace Community Church case the authors alert clergy to factors of competency, training, supervision, and litigation as essential and necessary factors to consider in working with suicidal persons. Asserts that clergy have an indispensable and crucial role to play in the holistic treatment of persons suffering from clinical depression which may lead to suicide-threatening behavior.

The United Methodist Church. "Suicide: A Challenge to Ministry". The Book of Resolutions Nashville. The United Methodist Publishing House. 1988. Pgs. 317 - 322.

An excellent example of what a church body can resolve to do after careful study by clergy and laity.

AUDIOVISUALS

About Stress Management. Channing L. Bete, Co., Inc. 200 State Road. South Deerfield, MA. 800-628-7733. 20 minutes.

Stress is normal - it's a part of everyone's life. But too much stress, without relief, can have disastrous effects. This video is designed to help people understand what stress is and how it affects them and to teach people how to better manage stress in their lives. The video comes with presentation tips, a quiz and review guide. The video is designed for stopping the tape for group participation.

Amy and the Angel. Coronet/MTI Film & Video. 108 Wilmot Road. Deerfield, IL. 60015. (800) 621-2131. Ask for "Jan". 30 minutes.

Depressed about her lack of social life and her parent's divorce, 17 year old Amy considers suicide. Then her guardian angel shows her how dismal life would have been if she'd never been born. Amy realizes that things really aren't as bad as they seemed, and she now faces life with new optimism and self-esteem. Features an appearance by James Earl Jones. " I feel the film can impact on both the insensitive students who harass the 'less than lovely' as

well as those contemplating suicide," says Elisabeth Wayland, School Social Worker. (ABC Afternoon Special) Emmy nominee.

A Tribute to Tim. Suicide Prevention & Education Center. 982 Eastern Parkway. Louisville, KY. 40217.

The video shows a suicidal student being saved by his friend even when the teacher they seek out is too busy to help. The story line is based on the premise that kids model the behavior of others. The fact that the music is intense, the plot races along, and the saga is complete with a trick ending that ensures no one will fall asleep while viewing this cliff hanger.

The Choice. Naval Imaging Command, Bldg. 168, Anacostia, NDW Washington, D.C. 20374. 1990. Identification Number: 804270DN. 30 minutes.

Intervention strategies are presented in a case study format. The narrator describes the signs of at risk behavior in two Navy members. The viewer listens in on a suicide prevention brief being given by a Navy chaplain and the narrator reinforces and amplifies the information using the case study examples.

Depression and Suicide. "The Power of Choice Series". Michael Pritchard. Coronet/MTI Film and Video, Inc. (Distributor). 420 Academy Drive. Northbrook, ILL. 30 minutes.

Michael Pritchard, juvenile probation officer turned stand up comic tours the U.S. talking to high school students about how they make choices in life. Focus is on the student small groups in which individual students speak about how they feel, cope and react to depression and ideas of suicide.

Everything to Live For. Coronet/MTI Film and Video. 108 Wilmot Road. Deerfield, IL. 60015. 24 minutes.

Viewers learn about the various organizations founded to help troubled teens deal positively with their problems. The film increases awareness of the family and social pressures which often force teenagers to the brink and the warning signals which usually precede a suicide attempt.

Hear Me Cry. Coronet/MTI Film and Video. 108 Wilmot Road. Deerfield, IL. 60015. 30 minutes.

The alarming problem of adolescent suicide is the basis for this compassionate drama. Two boys develop a close friendship as a result of serious difficulties each is experiencing in relationships with their parents. But their mutual unhappiness only heightens their feelings of despair and when a suicide pact results in the death of one boy, a tragic moment of trust confronts all concerned. This is a CBS School break Special.

Ministering To Suicidal Persons and Their Families. Stephen Ministries. 1325 Boland. St. Louis. Missouri. 63117. One hour divided into three parts.

Dr. Rosenthal provides information in a lecture format. He directs his lecture to middle management persons and counselors. He provides basic knowledge about suicide issues, such as the holiday season myth and identifying danger periods when one is at risk. With its accompanying Leader's Guide and Participant Outline, the video will help viewers

understand why people commit suicide, equip people with basic prevention knowledge and educate teens and parents about suicide.

Perfect Peace. Maranatha Music. Moody Videos International Bible Society (Distributor) 800-524-1588, ask for "Virginia".

This is a video of wonder and awe. It is a visual and aural encounter with the splendor of a Holy and Majestic God who speaks to both the individual and collective hearts of people. Contemplative music combined with scenes of nature invite the viewer to discover anew the comfort of God's promises and magnificence of God's handiwork.

NOTE: OUTUS commands - your local AFRTS affiliate has a copy of this video in their Library Materials. You will not be able to borrow the video, but can request it be shown locally on your AFRTS channel.

Poor Man, Rich Man. International Video Production. Franciscan Communications (Distributor). 1-800-421-8510. 75 minutes.

"People today are looking for new life-styles and values they can trust. St. Francis offers truth, simplicity and unconditional love. In this video St. Francis speaks to us today through the language of mime and music". -Cardinal Basil Hume.

Seasons of Healing: Winter into Spring. Darrell Adams. Music. Christopher Hammon. Photography. Journal of Pastoral Care Publications. 1549 Clairmont Road, Suite 103. Decatur, GA. 30033 (404) 320-1472. 30 minutes.

A videotape to reduce stress, renew spirit, and nurture hope. This is the first videotape of a series combining nature video photography with hymns. Featuring the hymns "Come Ye Disconsolate," "O Love That Will Not Let Me Go," "It Is Well," " 'Tis a Gift to Be Simple," and "Amazing Grace," this videotape moves from the cold of winter to the warmth of spring.

Stress: It's Just What You Think. Barr Films (Distributor). 12801 Schabarum Av. P.O. Box 7878. Irwindale, CA. 91706 (800) 234-7878. 20 minutes.

This is a film that guides young people to understand stress in their lives and teaches them positive ways of managing it. Viewers will learn to recognize their stress for what it is and trace its causes. Then, interviews with other teenagers demonstrate ways of removing or reducing stress by changing the situation, changing oneself and ones attitudes, and by learning to relax. Peace of mind is important part of good health and it comes from positive attitudes about oneself and an ability to manage the stress that is with us every day.

The Stress Mess. Training Images International (Distributor). 7334 Topanga Blvd. Suite 117. Canoga Park, CA. 91303. (800) 882-9436, ask for "Leslee". 25 minutes.

This film by Ron Underwood and Brent Maddock is a humorous, yet hard hitting film that shows how to identify the sources and signs of stress in our lives. It teaches us how to reduce and manage stress. It explains important time management techniques. The film allows people to see themselves in a realistic yet non-threatening way. And, it shows them simple ways to reduce stress and make life more productive...and enjoyable.

Stress Reduction Strategies That Really Work!. Human Relations Media. 175 Tompkins Avenue. Pleasantville, N.Y. 30 minutes.

This video provides information on how people react to stress (positive or negative) and details step-by-step techniques proven effective in reducing or eliminating stress symptoms. The program demonstrates that each individual has his/her own coping style and ways of dealing with various types of stressors.

Suicide Survivors. Films for the Humanities & Sciences (Distributor) PO Box 2053. Princeton, N.J. 08543. (800) 257-5126. 26 minutes.

The pain of survivors is acute after any death, but the grief inflicted by suicide may be the hardest to bear. Because suicide is sudden, often violent, and weighted with the added burdens of guilt and stigma, it is perhaps the most difficult to resolve. This program explores the special needs of suicide survivors, the role of suicide survivor groups in helping survivors cope with the bereavement process.

Suicide: The Parent's Perspective. Films for The Humanities & Sciences. PO Box 2053. Princeton, N.J. 800-257-5126. #SD-2352. 26 minutes.

This video seeks to help parents listen to their teens with greater awareness and to help them identify some of the symptoms of serious trouble. There is a companion video entitled, Suicide: The Teenager's Perspective, #SD-2351, which deals with one promising solution in suicide prevention, i.e. peer groups. It addresses ways teens can recognize the signs of impending suicide in their peers.

Surviving Depression. Clayton Barbeau Franciscan Communications (Distributor). 1229 South Santee Street. Los Angeles, CA. 26 minutes.

In this program Clayton helps us come to terms with the signs of depression which include: changes in eating habits and sleeping habits; inattentiveness, a sense of alienation, and even thoughts of suicide. He, then addresses the tactics of survival. This video is one of a series of videos which includes: "Surviving Loneliness", "Surviving Rejection and Failure" and others.

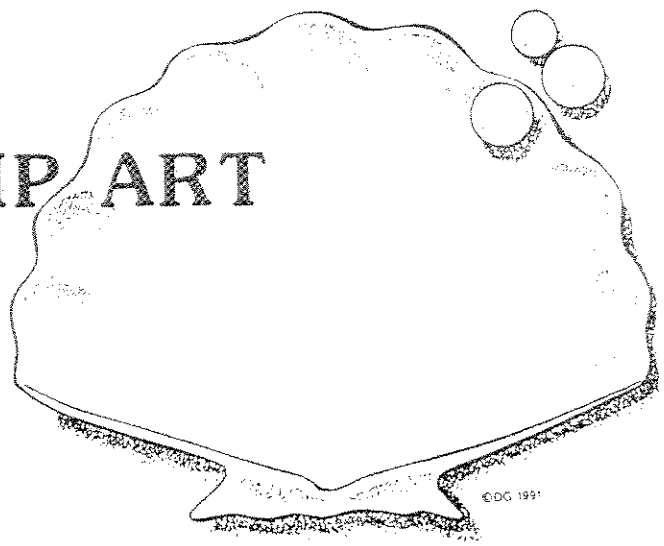
The Waters of Mount Desert Island. Ken Medema, Music. Christopher Hammon, Photography. Journal of Pastoral Care Publications. 1549 Clairmont Road, Suite 103. Decatur, GA. 30033. (404) 320-1472. 48 minutes.

A videotape to reduce stress, renew spirit, and nurture hope. Video photography from the Acadia National Park in Maine is woven together with an original piano score composed and performed in harmony with the natural sounds of the island to make this an extremely relaxing experience.

The Joy of Stress. Training Images International (Distributor). 7334 Topanga Bl. Suite 117. Canoga Park, CA. 91303 (800) 882-9436, ask for "Leslee". 20 minutes.

Best-selling authors Dr. Peter Hanson and Dr. Kenneth H. Blanchard give practical, no-nonsense advice for getting a handle on stress and turning it into a positive force for higher productivity and performance. They encourage the viewer to form these healthy habits: * Identify and balance priorities * Get feedback and support from others and * Follow a nutritious diet and a program of regular exercise. Leader's Guide included.

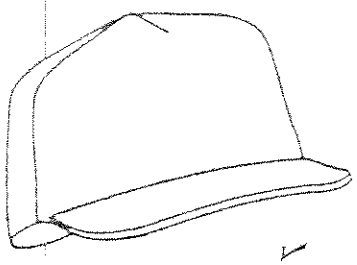
CLIP ART



FOR
PROGRAM DEVELOPMENT

WHAT TO DO

--If you believe that someone may be suicidal--



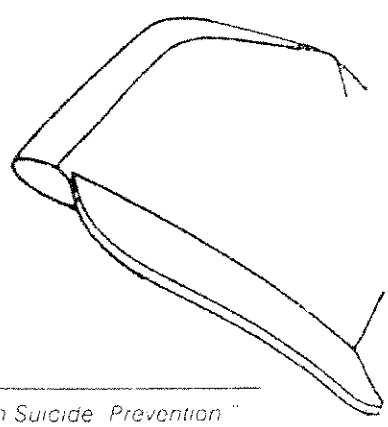
- Take threats seriously. Give some thought to what the person says. It may not be just idle talking.

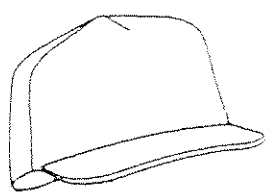
- Answer cries for help. Offer support, understanding and compassion. Remember that the person is in emotional pain.

- Confront the problem. If you suspect that a person is suicidal begin asking questions. Be direct. Be a good listener. Do not make moral judgments, act shocked or make light of the situation.

- Tell them you care. Assure the person that some help is available and provide encouragement with helpful listening.

- Get professional help. Offer to go with them or take them to help. If you are unsuccessful, tell someone else about the person, i.e. your division officer, the chaplain, the career counselor.





THESE FACTS MAY ANSWER QUESTIONS

...YOU HAD IN THE PAST

...YOU MAY BE ASKED IN THE FUTURE...

- ✓ People who talk about suicide ***DO*** kill themselves.
- ✓ People generally ***DO NOT*** want to die. They have eliminated alternatives WITHOUT consideration.
- ✓ People who kill themselves are generally ***NOT*** crazy. They are in emotional pain, angry or depressed.
- ✓ Most suicides ***ARE*** planned.
- ✓ People who have attempted suicides, and their crisis continues, are at higher risk for a successful attempt.
- ✓ Talking to an individual about your concern/suspicions ***DOES*** help.

WARNING SIGNS

- ✓ Suicide Ideation; Gesture or Attempt
- ✓ History of Suicidal Behavior
- ✓ Depression (Apathy, Anxiety, Sleeping Difficulty, Hopelessness)
- ✓ Personality Changes
- ✓ Makes Arrangements to Give Belongings Away
- ✓ History of Family Violence/Turmoil with Current Marriage
- ✓ Alcohol Use Increases

This list of symptoms is in no special order nor are they of equal weight. But, the more of these symptoms the individual exhibits the more likely the potential for suicide.

The Basics of

EVALUATING A SUICIDE

CONFUSION. The potential suicide has a marked inability to separate and evaluate problems.

FEAR OF THE FUTURE. Although it may sound incongruous, many persons commit suicide because they fear death. "I know it's cowardly to think of suicide," they say, but actually they are thinking that if they can accomplish suicide they won't have to fear the things that really worry them.

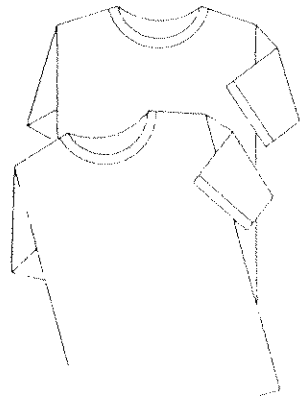
URGE TO KILL. The potential suicide may be seeking revenge, thinking, "You may be sorry when I'm gone." This is a dangerous attitude because it may give birth to homicide.

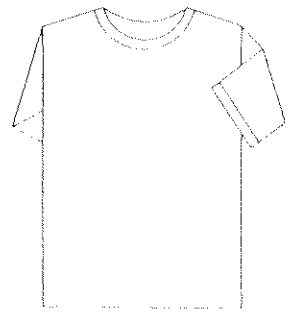
LACK OF ROOTS. Very few persons commit suicide in the town or region of their birth. The farther away from home, family connections, and close friends a person gets, the more likely suicide becomes.

MEANS. A suitable suicidal tool is available. This factor carries double weight if the person frequently mentions having the tool.

WITHDRAWAL. The potential suicide often systematically eliminates social contacts. Dropping out of clubs, church, hobbies, and avoiding old friends. This reinforces such inner feelings as, "I'm not needed."

A VAGUE ILLNESS. Frequent complaints about indefinite physical illness, "an ache all over feeling," or chemical psychosomatic signs reflect a high degree of disorganization.





NEGATIVE PROTEST. This is a tricky factor. If a person tells you in an overemphatic manner, that he/she is not contemplating suicide, be careful.

FINANCIAL REVERSE. Here, it is apparently the loss of status as much as the loss of money that is significant.

RATIONALIZATION. Occasionally the potential suicide will attempt an aggressive defense of suicide. This is especially true in the cases where the subject is following the footsteps of a relative.

PREVIOUS ATTEMPT. Recent studies agree that approximately 75% of accomplished suicides have made a previous attempt.

FAMILY HISTORY. Statistically, persons who have had a suicide in the family are more likely to commit or attempt suicide.

SUICIDE
FACT or FICTION

An encounter with a suicidal person is always a deeply moving experience. There is a fear of not knowing what to do, or doing the wrong thing.

There are many myths about suicide which keep us from becoming involved.

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

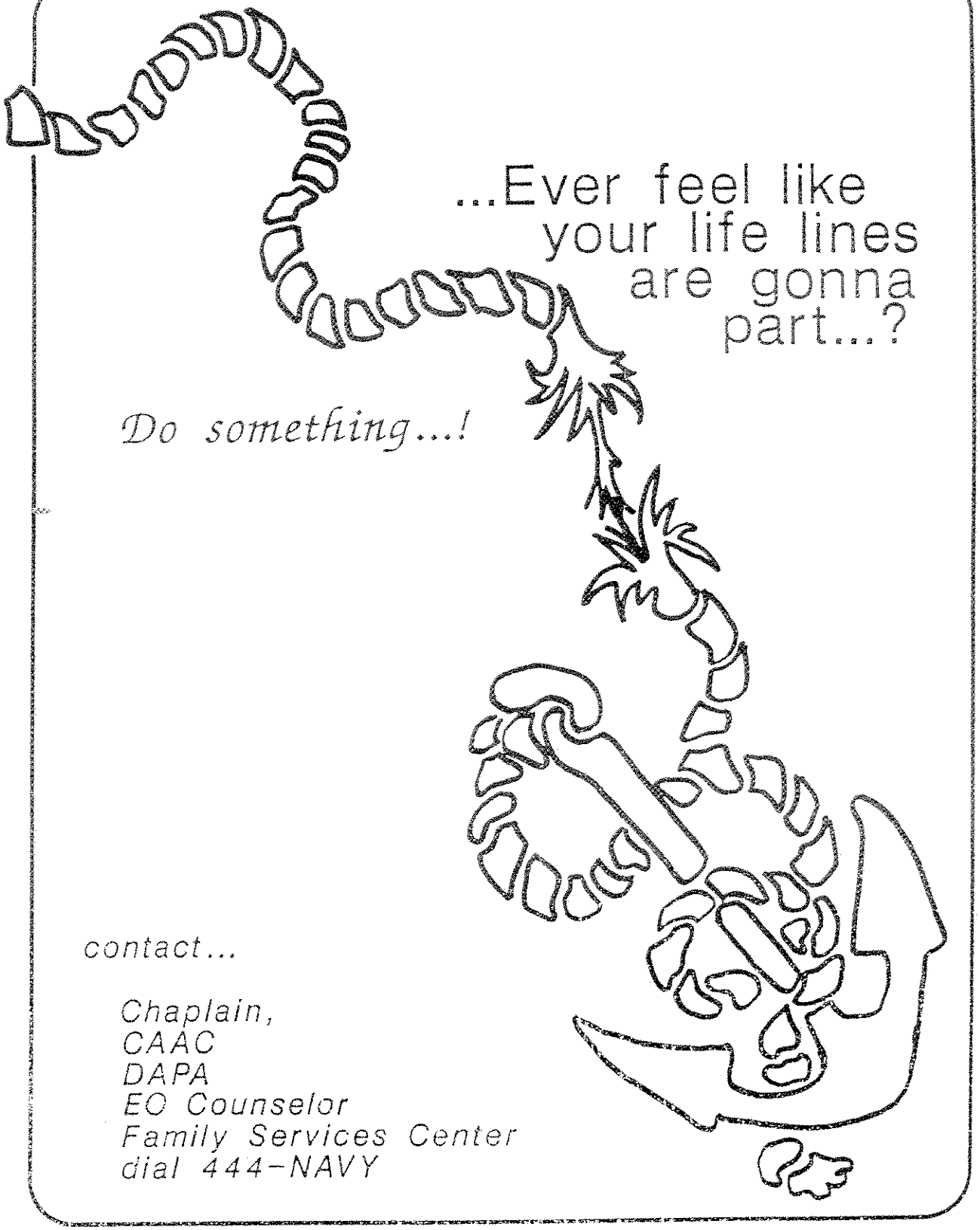
FABLE: All suicidal individuals are mentally ill.
FACT: Although extremely unhappy, the person is not necessarily mentally ill.

FABLE: Suicide is an act of impulse with no previous planning.
FACT: Most suicides are carefully planned and thought about for weeks.

FABLE: A person who attempts suicide will not try again.
FACT: Most people who commit suicide have made previous attempts.

FABLE: Because it includes the holiday season, December is a high suicide rate.
FACT: Nationally, December has the lowest suicide rate of any month.

FABLE: People who commit suicide are people who were unwilling to seek help.
FACT: Studies of suicide victims have shown that more than half [illegible]


...Ever feel like
your life lines
are gonna
part...?
Do something...!
contact...
Chaplain,
CAAC
DAPA
EO Counselor
Family Services Center
dial 444-NAVY

DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF OF NAVAL OPERATIONS
WASHINGTON DC 20350-2000

IN REPLY REFER TO
1734/9
Ser CRB:C12/256
31 Jan 86

Dear Chaplain:

Suicide is the third leading cause of death among those age fourteen to twenty-five. More than 6,500 young Americans take their own lives annually. Each death is a tragedy.

As chaplains, we are in constant contact with our young adults in worship, religious education, counseling, and visitation.

The enclosed materials are provided that you might be better equipped to identify the young man or woman who is at risk and bring him/her to the attention of command and medical assistance.

Recognizing our limitations in this area, chaplains should not hesitate to use competent referral services.

To facilitate training on the local level, we have provided a copy of the video "Suicide: The Warning Signs" to Area Coordinators in nineteen key geographic locations.

If we can save a single life through our alertness, we will have given a gift beyond measure.

Sincerely,

John R. McNamara

JOHN R. MCNAMARA
Rear Admiral, Chaplain Corps
United States Navy
Chief of Chaplains

AREA COORDINATORS LISTING

Command Chaplain
Commander, Naval Base
Norfolk, VA 23511-6002

Fleet Chaplain
Commander in Chief
U.S. Atlantic Fleet (Code N0010)
Norfolk, VA 23511-6292

Command Chaplain
Naval Station
Box 139 (Code OR)
San Diego, CA 92136

Command Chaplain
Naval Administrative Command
Naval Training Center
Great Lakes, IL 60088-5100

Command Chaplain
Naval Air Station
Jacksonville, FL 32212-5000

Command Chaplain
Naval Submarine Base, Bangor
Bremerton, WA 98315-5000

District Chaplain
Building 72, Anacostia
Washington, DC 20374-0721

Command Chaplain
Naval Station
P.O. Box 47
Pearl Harbor, HI 96860-6000

Fleet Chaplain
Commander in Chief
U.S. Pacific Fleet
Pearl Harbor, HI 96860-7000

Command Chaplain
Naval Submarine Base, New London
Groton, CT 06349-5013

Command Chaplain
Marine Corps Base
Camp Smedley D. Butler
FPO Seattle 98773-5000

Command Chaplain
U.S. Naval Station
Box 16
FPO San Francisco 96651-1012

Command Chaplain
U.S. Naval Support Activity
Box 14
FPO New York 09521-1000

Fleet Chaplain
Commander in Chief
U.S. Naval Forces, Europe
Box 2
FPO New York 09510-0158

Command Chaplain
Naval Station (Code 05)
Building NS-31
Charleston, SC 29408-5000

Command Chaplain
Naval Station
Building 104
Philadelphia, PA 19112-5084

Director
Chaplain Resource Board
6500 Hampton Boulevard
Norfolk, VA 23508-1296

Director
Naval Chaplain School
Naval Education and Training Center
Building 114
Newport, RI 02841-5014

Staff Chaplain
Chief of Naval Education and Training
(Code 012)
Naval Air Station
Pensacola, FL 32508-5100

SUPERVISOR'S ROLE IN SUICIDE PREVENTION

- Know your personnel. Be keenly aware of changes in attitudes, behaviors, performance.

- Identify "at risk" sailors. Spot individuals with problems and get help for them.

- Be a leader who is actively concerned about welfare and morale within the command. It is important that you show interest in the problems of your sailors and their families.

- Be aware of resources that can help you help your people.

- Be available. Be supportive. Be an active listener...
  - °Reassure the sailor that you will listen and try to help him/her.
  - °Temporarily "put yourself in the sailor's shoes" and try to understand what he/she is feeling.
  - °Allow the sailor to talk. Don't judge his/her actions. Don't try to cut off the conversation. Don't belittle or criticize what they are saying.

- Know the suicide warning signs and risk factors.

- If a sailor attempts or threatens suicide, take it seriously. Follow emergency procedures:
  - °Do not leave the individual alone.
  - °Call for professional help IMMEDIATELY.

TAKE ALL THREATS SERIOUSLY!

Prepared by
Chaplain Resource Board
NAVMEC

NAVMEC SUPERVISOR'S GUIDE TO SUICIDE PREVENTION

"WHOEVER PRESERVES ONE LIFE,
IT IS AS IF HE PRESERVED
AN ENTIRE WORLD."

-FROM THE TALMUD

SUICIDE FACTS

Do you know that...

- Suicide is on the rise nationwide.
- The most common cause for sailor suicide is difficulty in a relationship (divorce, break-up, separation) or family problems.
- The second most common cause for sailor suicide is difficulty with job, or the Navy.
- Approximately 80% of all suicide victims give some advance warning of the suicide.
- Sailors take their lives most often by violent means such as firearms or hanging.
- Most sailor suicides occur in homes, quarters, or barracks/ships.
- Among sailors, alcohol is related to 41% of completed suicides
- Among Navy suicides, almost 40% had a history of previous psychiatric disturbance.
- Suicides can be prevented by supervisor's involvement and action.

RESOURCES

For supervisors, sailors, and families:

- <u>During working hours</u> (0800-1630)
  - Sewells Point Clinic
    EMERGENCY 444-1531
    444-1532
  - Sewells Point Family Services Center
    Information & Referral 444-6289
    Appointments & Programs 444-2102
  - Naval Hospital Portsmouth
    EMERGENCY ROOM 398-5064
    Information Office 398-5000
    398-5001
    Chaplains Office 398-5550
  - NAVMEC Chaplains 444-7665
    444-7666
- <u>After working hours</u>
  - Sewells Point Duty Officer
    NAVSTA OOD 444-7156
    444-7157

24 HOUR CRISIS LINE
399-6393

SUICIDE WARNING SIGNS

- Verbal statement of wish to die or direct threat of self harm.
- An unusual interest in or talk about the subject of death--reflected in speech, art, letters, etc.
- Talk about feeling worthless.
- Decline in job performance and/or personal appearance.
- Changes in sleep patterns and/or appetite.
- Drug or alcohol abuse.
- Unusual withdrawal, isolation, aggression, disinterest, moodiness, or crying spells.
- Making final arrangements, giving away favorite possessions, writing a will.
- Being accident prone.
- Depression over recent death of friend or relative.

SUICIDE RISK FACTORS

The suicide risk is higher in a person who:

- Has problems with family, relationships, job, Navy, finances.
- Has made previous suicide attempts.
- Has a family history of suicide.
- Has experienced a recent suicide of a friend or relative.
- Threatens suicide.
- Has possession of a weapon.
- Has specific, well-thought out plan.

DEPARTMENT OF THE NAVY
NAVAL CONSTRUCTION BATTALION CENTER
GULFPORT, MISSISSIPPI 39501-5000

IN REPLY REFER TO

5720
Ser 16/180
September 15, 1993

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

Dear Mr. Moldeven:

In response to your request for information concerning the CBC Gulfport suicide prevention program, enclosures (1) and (2) are provided.

Your interest in suicide prevention and intervention in the armed forces is appreciated.

Sincerely,

DAPHNE L. PUTZIER
LT, JAGC, USNR
Staff Judge Advocate

Encl:
(1) Family Service Center Psychiatric Emergency Standard Operating Procedures
(2) CBCGPTINST 1700.13

Psychiatric Emergency
Standard Operating Procedures
Family Service Center

I. Introduction and Discussion

A psychological crisis is a painful internal state that occurs when an individual attempts to cope with stressful environmental or internal stimuli. A crisis may have a positive or negative outcome depending upon the skills and resources of the individual and his or her ability to effectively adapt. Many individuals present to Family Service Center counselors in crisis; crisis intervention involves the use of a wide range of therapeutic skills and procedures.

A psychiatric emergency is a disturbance in thoughts, feelings or actions for which immediate medical treatment is necessary. Psychiatric emergencies exist when the client's inability to resolve the crisis leads to dysfunctional behavior which disrupts daily living patterns. Types of psychiatric emergencies include severe depression, suicidal behavior, homicidal behavior or ideation, violent "acting out," psychotic breaks, and decompensation of chronically mentally ill individuals. In assessing for psychiatric emergency states, as in all other occasions, counselors should be professionals with therapeutic skills who are capable of exercising excellent clinical judgment.

Psychiatric emergencies are medical emergencies. Counselors at Family Service Center, however, often do triage of clients in need of emergency services. As such, counselors should always assess for situations in which the client is at risk for intentionally or unintentionally harming himself or others. Specifically, we must assess for suicidality and homicidality in addition to the typical practice of assessing for the need for inpatient or outpatient mental health services.

Suicide and homicide have been described as resulting from very similar motivations, with the target of action differing from "self" with suicide to "other" with homicide. An ethical responsibility exists for counselors to respond to suicidal ideation; ethical and legal responsibilities exist for response to homicidal ideation. No right to confidentiality exists in cases when harm is threatened; the confidentiality statement signed by the client clearly informs him or her of your obligations.

II. Procedures

A. During normal working hours, suicidal or homicidal

When individuals present to the Family Service Center during normal working hours, either by phone or in person, receptionists and counselors should be sensitive to the behavioral state of the

individual. If the individual is "out of control," "can't take it anymore," "completely falling apart" or otherwise similarly distressed, the client should be seen or talked to immediately by a counselor or the Information and Referral Specialist.

1. Phone contact

If the client is on the phone, they should be asked to go to the Branch Medical Clinic or to Keesler as an emergency walk-in at mental health. All identifying information (name, command, address, phone number) should be obtained and forwarded (in person or by phone) to the individual or agency who will be seeing the client. Additionally, a brief description of the presenting problem should be shared. Arrange transport if needed by calling command (active duty members) or an ambulance. If the attempt is in progress, notify the police and command as needed. Use the flow chart (Attachment (1)) for guidance.

2. In person

Clients presenting in person with intense depression, grief, anger, loss of control or feelings of being overwhelmed should be evaluated for suicidal/homicidal ideation using similar questions. An important first step in assessing a client for current level of suicidal or homicidal risk is directly asking the client about his intent and plans. Ask either "Have you been thinking of killing/hurting yourself or someone else?" or "How often do you have thoughts about harming yourself?" If suicidal or homicidal thoughts are acknowledged, the counselor must then inquire about 1) the plan; 2) viability of the plan, i.e., access to materials, likelihood of harm arising; 3) past history of suicidal/homicidal actions, and 4) the possible value of social support resources (presence of others in home, etc.). Attachment 2 provides a checklist/guide for assessing the situation and recommends ratings of lethality and probability based on information about the presented situation. This information can be shared with medical personnel when the individual is referred. It is recommended that any client presenting with suicidal or homicidal ideation, regardless of lethality or probability of attempt, be referred to a medical facility for evaluation.

If the individual is presenting with thoughts and feelings associated with suicide, the individual must be referred to a medical facility immediately.

a. Dependents

For dependents, if the individual has a friend or relative with them, the counselor should speak to that individual and ask that he or she transport the victim to the Branch Medical Clinic. If the individual is alone, the counselor should call Security to ask for an escort for the suicidal individual to the clinic. When calling Security, give a current status report, state specifically what assistance is required, and inform whether an attempt is in progress.

b. Active Duty

For active duty members, the service member's command must be contacted. When contacting command, give a current status report, state specifically that escort is required, and inform whether an attempt is in progress.

After the escort has been arranged, notify the Branch Medical Clinic that the person will be presenting to medical. Call the Clinic, speak with the duty (or battalion) physician, inform of the situation, and inform that you will FAX a copy of the assessment sheet with all identifying information to him or her. After speaking with medical, forward the forms. See Attachment (3) for a flow chart of the process.

For homicidal clients:

When risk for harm to self is imminent, hospitalization is the recommended means of insuring safety. Medical will make the call. When risk for harm to other exists in any degree, hospitalization may be the recommended treatment for the potential perpetrator but additional steps to insure the safety of the intended victim must also be taken. Counselors should contact the appropriate police or security agency to inform them of the potential danger situation.

B. Normal working hours, hospitalization

Occasionally a client will be seen who will probably require inpatient mental health hospitalization, either because of a psychiatric emergency or because or a severe psychiatric disability. Keesler Air Force Base Medical Center is the primary mental health facility used for military and military dependents. If Keesler has beds available, CHAMPUS will not pay for other hospitalizations. All active duty service members must go to Keesler. The procedure for referral of dependents is as follows:

Call the Branch Medical Clinic (871-2809) and arrange for an appointment with the duty physician. If the client is provisionally suicidal or homicidal, request an escort from Security for the trip from the Family Service Center to the clinic. Medical will then have the responsibility for arranging hospitalization if needed or in arranging further services. See Attachment (4).

Some individuals will have suicidal or homicidal ideation, but will be medically diagnosed as at no immediate risk. These individuals do require a complete mental health evaluation as soon as possible. The client can be sent via "emergency walk-in" procedures to Keesler Mental Health Clinic during working hours or Keesler Emergency Room after hours. A medical official can make arrangements or we can make calls at medical's request and

our convenience.

II. After normal working hours

In cases where a counselor is apprised after normal working hours of a client's potential suicidality or homicidality, the resources of the community and the military hospital system are to be used. Suicidal clients able to be transported by family or friends should be transported to Keesler Medical Center. In cases where no such resource exists, local police should be given information and the civilian system's resources used. Please see Security SOP and flowchart, Attachment 5.

DEPARTMENT OF THE NAVY
NAVAL CONSTRUCTION BATTALION CENTER
GULFPORT, MISSISSIPPI 39501-5000

Code 16

IN REPLY REFER TO
CBCGPTINST 1700.13
Code 13
18 SEP 1991

CBC GPT INSTRUCTION 1700.13

From: Commanding Officer

Subj: SUICIDE PREVENTION

Ref: (a) CNO Washington DC 181814Z Sep 87 (NAVOP 086/87)
(b) CNO Washington DC 022121Z Dec 88 (NAVOP 126/88)
(c) CNTECHTRAINST 1700.3
(d) MILPERSMAN 4210100

1. Purpose. To establish policy and provide guidance and responsibilities for local coordinated efforts in the prevention of suicide at Naval Construction Battalion Center (CBC), Gulfport.

2. Background. Suicide is the third leading cause of death in the naval service. Young adults are a particularly vulnerable age group; however, experience shows that no one is immune to the possibility of suicide. Suicide is a tragedy for our families and for the naval service. Both are diminished by every loss. References (a) through (c) promulgate policy and guidelines for suicide prevention efforts, stressing increased command involvement. The lack of self esteem and feeling of worthlessness which underline many suicide behavior patterns, significantly undermine the Navy's emphasis on personal excellence and become barriers to self improvement. It has been demonstrated that caring leadership and a responsible broad-based support system are the keys to effective suicide prevention. Human understanding is the most effective weapon against suicide.

3. Action. The following actions will be taken to coordinate local efforts in support of a proactive suicide prevention program.

a. The Family Service Center Director is hereby designated as the CBC Gulfport Suicide Prevention Project Officer with responsibility for establishing a Suicide Prevention Program Committee. This committee shall:

(1) Meet at least quarterly to coordinate local efforts, share facts, recommendations, lessons learned and to plan programs which combine available assets.

(2) Have as members, the Command Chaplain, Medical Officer, Family Service Center Director, Family Service Center Director of Counseling, and tenant command representatives.

(3) Use all opportunities, including speeches, messages, Plan of the Day and newspaper articles, to put out the word that prevention of suicide is a concern of the Navy and a personal goal of the Commanding Officer.

b. Commanders/Commanding Officers/Officers in Charge of tenant commands shall designate a representative to attend meetings and act as a point of contact for two-way information flow. This representative should:

(1) have access to their commanding officer/officer in charge and input at department head meetings; and

(2) be completely familiar with their command's efforts and initiatives in the area of suicide prevention and/or stress management training.

c. Officer in Charge, Branch Medical Clinic, shall designate a medical officer, knowledgeable in the area of suicide prevention and stress management, to serve on the committee.

4. Training. The Family Service Center, per reference (a), will coordinate training in conjunction with medical and chaplain personnel. Training shall include:

a. Core values/ethics training to support anti-suicide efforts and to attack low self esteem and promote the aspiration to personal excellence. This training is to be conducted by chaplains.

b. Leadership training to be conducted by the Project Officer to:

(1) reemphasize positive leadership which builds self worth;

(2) teach leaders to correct errors, but then to look for deeper problems;

(3) sensitize leaders at all levels to this issue to ensure no person is nameless, faceless or anonymous; and

(4) challenge all leaders to care enough for our people to save them.

c. Suicide Prevention/Awareness Training will include identification of persons at risk and intervention techniques and resources available. This training is to be conducted by Family Service Center and medical officers.

d. Stress management training to identify life stressors, learn coping management skills and resources available to assist individuals. This training is to be conducted by Family Service Center staff.

e. Use of the Plan of the Day notes and base newspaper to stress the idea that "Life counts; it is a gift which must not be wasted."

5. Reports

a. Report suicides, gestures and attempts to Chief of Naval Personnel (PERS-64) as required by reference (d). Include CBC Gulfport as the information addressee.

b. Report suicides, gestures, attempts, and ideations to the Suicide Prevention Project Officer.

c. Investigate the circumstances of all incidents and report lessons learned to improve training to the Suicide Prevention Project Officer.

d. The Suicide Prevention Project Officer shall provide a yearly report no later than 30 September. The report shall include:

(1) Statistics by command of

(a) suicides, and

(b) suicide gestures/attempts

(2) Training completed by commands of

(a) E-7 and above, and

(b) E-6 and below

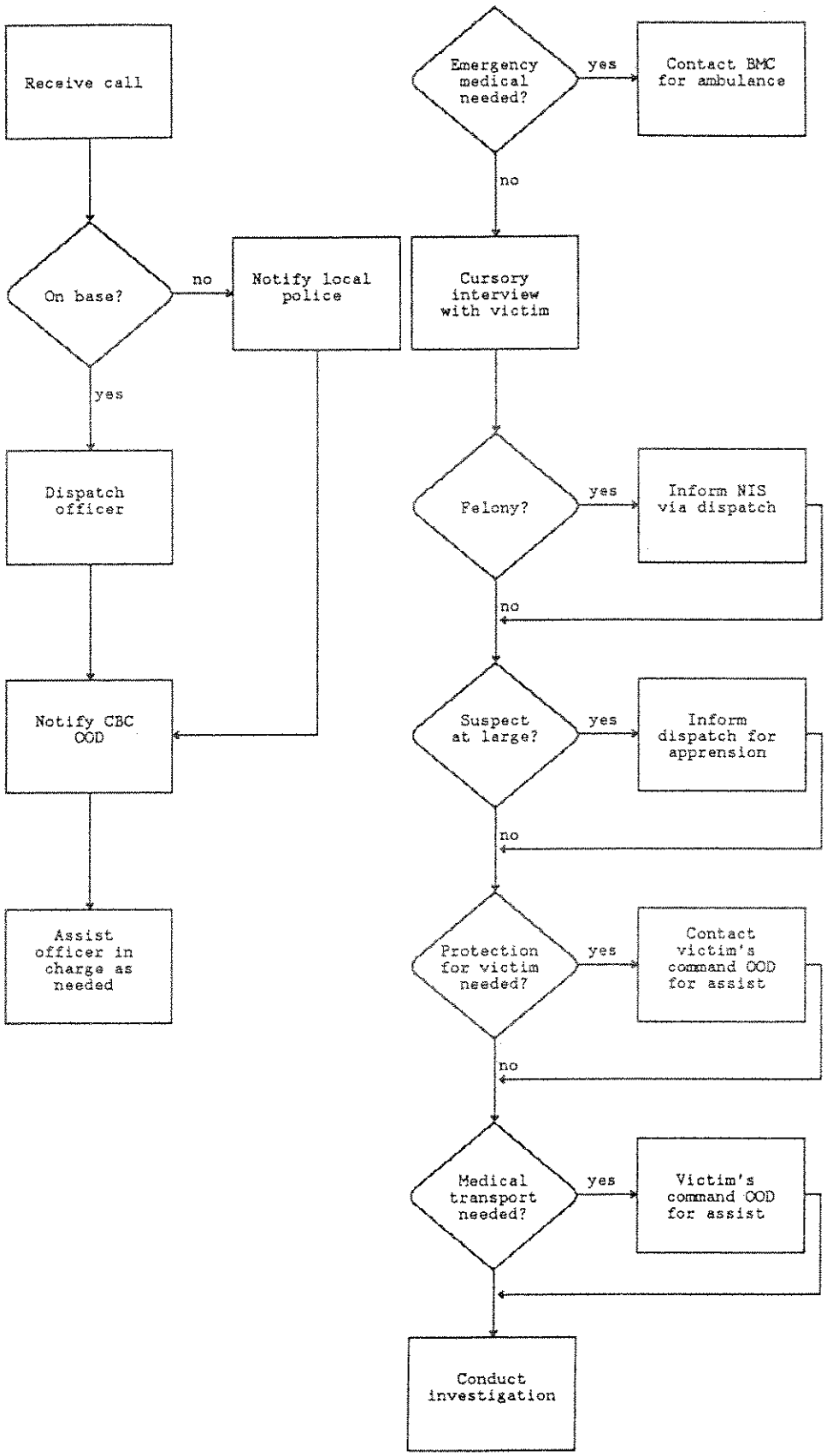
(3) Summarized narrative of lessons learned.

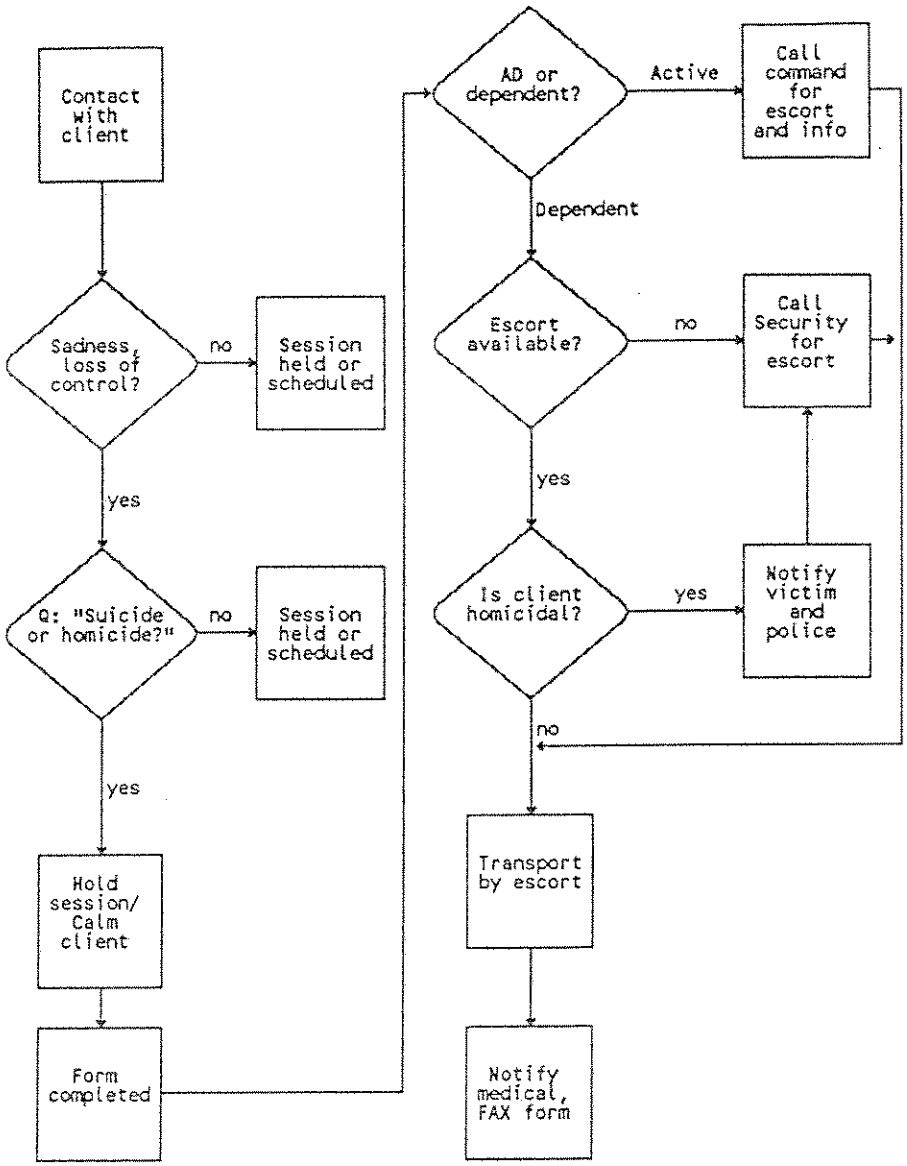
(4) Recommendations for improving training and preventive programs.

W.C. HILDERBRAND

Distribution:
List B
List D

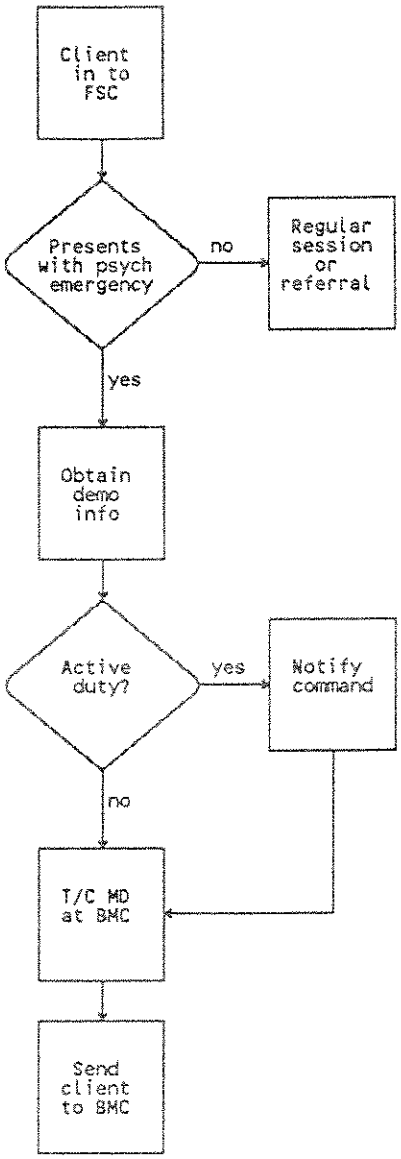
Copy to:
OOD Notebook


Receive call
Emergency medical needed?
yes
Contact BMC for ambulance
no
On base?
no
Notify local police
Cursory interview with victim
yes
Dispatch officer
Felony?
yes
Inform NIS via dispatch
no
Notify CBC OOD
Suspect at large?
yes
Inform dispatch for apprension
no
Assist officer in charge as needed
Protection for victim needed?
yes
Contact victim's command OOD for assist
no
Medical transport needed?
yes
Victim's command OOD for assist
Conduct investigation



PSYCHIATRIC EMERGENCIES --

IN-PERSON CONTACT



PSYCHIATRIC EMERGENCY --

HOSPITALIZATION

SUICIDE ASSESSMENT SHEET

Name _____ Date _____ Caller _____

I. First, complete the work sheet for lethality and probability of attempt variables. Using the completed work sheet, your experience, and your judgment, assess both lethality and probability of attempt below (Please circle)

LETHALITY			PROBABILITY OF ATTEMPT		
LOW	MEDIUM	HIGH	LOW	MEDIUM	HIGH

II. Describe Present Plan (include suicidal statements and clues):

III. Previous Suicide Attempts:

Dates: Method: Outcome:

_____

_____

_____

IV. Significant others (relatives, friends, therapists, helping agencies):

Name: Relationship: Address: Phone No. Present Communication

_____

_____

_____

V. Survivor's History (significant others who have suicided)

who _____

when _____

caller's response _____

VI. Ambivalence: Did the caller acknowledge ambivalence? ___

Living Clues: Dying Clues:

VIII. Plan of Action:

_____Own resources (specify)
_____ To Live Decision
_____ Dispose of means
_____ Eat, sleep, etc.
_____ Recontact FSC
_____External Resources:
_____ Counseling
_____ Contact Significant Other
_____Emergency Procedures:
_____ Ambulance/Police sent

LETHALITY	LOW	MEDIUM	HIGH
1. SUICIDE PLAN (describe on reverse)			
Method	__pills, slash wrist	__drugs & alcohol	__gun, hanging, jumping
Chance of intervention	__others present	__others available or expected	__no one nearby, isolated

PROBABILITY OF ATTEMPT	LOW	MEDIUM	HIGH
1. SUICIDE PLAN (describe on reverse)			
Details	__vague, no plan	__some specifics	__very specific
Time	__no specific time or in the future	__within a few hours	__immediately, or in progress
Availability of means	__not available, will have to get	__available, have close by	__have in hand or in progress
2. PREVIOUS SUICIDE ATTEMPTS (describe on reverse)			
Number/Lethality	__none or one of low lethality	__multiple of low lethality or one of moderate lethality, repeated gestures	__one high to multiple attempts of moderate lethality
When	__over two years ago	__six months to two years	__within last six months

3. INTERNAL RESOURCES			
Affect - Anxiety	__mild, some discomfort is felt	__moderate, discomfort is increasing but not overwhelming	__high, feels overwhelmed, may panic
Affect - Depression	__mild, feels slightly down	__moderate, increased feelings of sadness & hopelessness with a decrease of energy	__severe, overwhelming feelings of sadness & hopelessness with a marked energy decrease
Coping Behavior			
Daily functioning	__daily activities continue as usual with little change	__some daily activities are set aside, some disturbance in eating, sleeping, & work habits	__many daily activities are discontinued-gross disturbances in eating, sleeping, & work habits
Stress reaction	__no significant stress	__moderate reaction to loss, sickness, and other changes	__severe reaction to loss sickness, and other environmental changes
Present coping strategies	__generally constructive utilizing resources, verbalizing feelings	__some that are constructive, others that are maladaptive, increased drinking	__predominantly maladaptive, excessive drinking, drug usage, risk taking behavior
4. EXTERNAL RESOURCES (as perceived by caller - described on reverse)			
Availability	__help available, sign. others concerned and willing to help	__family & friends available but unwilling to consistently help, esp. financially	__family, therapist, clergy or employer hostile/ exhausted or injurious to caller
Communication	__frequent positive interaction with more than one sign. other	__positive interaction w/ at least 1 sign. other	__little and/or poor interaction w/sign. others
5. MEDICAL STATUS	__no significant medical problems	__acute (short term) psychosomatic illness (asthma, ulcers, hyperventilation, cramps)	__chronic (long term) illness, or acute catastrophic illness (cancer, rabies, etc.)
6. LIFE STYLE HISTORY	__fairly consistent work history, stable relationships, stable personality, no history of violent behavior	__crisis in stable personality, recent increase in long standing, disabling personality traits, some violence noted in past behavior, alcoholism	__chronic suicidal behavior in unstable personality recurrent outbreak of severe symptoms, difficulty in peer, family, and job relationships, repeated violent outburst

PSYCHIATRIC EMERGENCIES -- PHONE REPORTS