

## SPOT (GATEKEEPER TRAINING)

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

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

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

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

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

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

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

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

Table 2

**GATEKEEPER RESPONSIBILITIES**

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

## **GATEKEEPER LESSON 1 (BUDDY CARE)**

### **Lesson Plan Advance Sheet**

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

**Time:** 30 minutes

**Target Audience:** All personnel (OH 1) \*

#### **Terminal Individual Objective**

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

#### **Learning Objectives (OH 2)**

Participants will be able to:

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

#### **Soldier Preparation**

None

#### **Instructional Procedures**

Conference

\*OH = Overhead

HO = Handout

## Instructor's Notes

*Instructor Note:* Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. You must assume that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Also, you will seek to motivate members of the unit to become concerned for the well-being of friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

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

### **Preview Main Points (OH 3 a, b)**

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

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

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

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

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

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

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

### **Suicide Model (OH 4)**

In order to understand the responsibilities of a gatekeeper (*a concerned person who is in the position to **spot** suicidal behavior and render "first aid"*), a basic orientation to suicidal progression is essential. The previous lesson covered the primary suicide prevention aspects of **structure** and **screen**. When Prevention efforts fail to inhibit self-destructive thoughts and behavior, then the gatekeepers' role intensifies. The Army Suicide Model follows the DOD model developed by Dr. David Shaffer of Columbia University. This model helps us understand the progression of suicidal behavior and the critical points of intervention. The sequence of events in this model may progress very rapidly because suicide is often an impulsive act. Any stress event, however small, may "trigger" a mood change resulting in an emotional crisis. This "unable to cope" stage is a critical intervention point. Gatekeeper intervention, community support and the denial of access to a method of suicide are key to avoiding death by suicide. If a gatekeeper can **spot** the critical mood change and intervene, a mental health care professional can **secure** the individual and a life will be saved. The following general questions and answers about suicide will help in identifying those critical intervention points.

### **General Questions about Suicide**

#### 1. WHAT IS SUICIDE?

We could say that it is the deliberate ending of one's own life. Suicidal behavior includes (**OH 5**):

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

#### 2. WHY SHOULD WE KNOW ABOUT SUICIDE?

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

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

### 3. WHY DO PEOPLE COMMIT SUICIDE?

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

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

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

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

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

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

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

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

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

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

### **Depression and Hopelessness**

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

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

Hopelessness:

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

Depression:

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

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

## 6. WHO COMMITS SUICIDE?

More people die from suicide than from homicide in the United States. In 1997, 30,535 Americans took their own lives. In contrast, 19,491 were homicide victims. On average, 84 Americans commit suicide each day, and there have been more suicides than homicides each year since 1950. In 1997, suicide was the eighth leading cause of death in this country. It was the fourth leading cause of death among 25- to 44-year-olds.

Suicide is a serious problem among young people. Between 1980 and 1997, the rate of suicide increased 109% for 10- to 14-year-olds and 11% for 15- to 19-year-olds. Suicide was the third leading cause of death for 15- to 24-year-olds in 1997. That same year, a nationwide survey of high school students found that in the previous year, one-fifth had seriously considered suicide and 1 in 13 had attempted it.

Most suicides are males. In 1997, males accounted for 80% of all suicides in the United States. Among 15- to 19-year-olds, boys were five times as likely as girls to commit suicide; among 20- to 24-year-olds, males were seven times as likely to commit suicide as females. Although more females attempt suicide than males, males are at least four times as likely to die from suicide.

Anyone, at any age, can complete suicide. Recent studies reveal that the suicides in the U.S. Army follow a bi-modal pattern. The first increase is in the 20 – 29 age group. These tend to be impulsive acts stemming from substance abuse, relationship and financial problems, and UCMJ actions. The second group is the 40 – 49 age category. These suicides often stem from relationship failures, substance abuse and mood disorders. (OH 7).

One interesting study shows that the number of U.S. Army Reserve Component and Army National Guard suicides doubled from 1998 to 1999. (OH 8)

The rate of suicide in the military over the past 10 years has essentially held steady. The number of nonfatal attempts is, of course, much higher. These attempts and completions have left their mark on thousands of fellow soldiers, friends and family members. Suicide numbers and rates change with the completion of investigations, so, for current data, please see the Office Of The Deputy Chief of Staff, Personnel (ODCSPER) Website for current rates: <http://www.odcsper.army.mil/default.asp?pageid=66f>. In the 1990's, the Army lost a battalion equivalent (800 persons) to suicide. (OH 9)

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

It is important to know relevant myths and facts about suicide because these can influence people's attitudes toward suicidal individuals and toward taking action on their behalf.

Specifically, many myths contain rationalizations that can prevent people from taking action when they suspect or are confronted by someone who is at risk for suicidal behavior.

MYTH: Most suicides occur with little or no warning.

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

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

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

Rationalization: It is best just to avoid it altogether.

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

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

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

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

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

Rationalization: These behaviors can either be ignored or punished.

FACT: For some people, suicidal behaviors or "gestures" are serious invitations to others to help them live. If help is not forthcoming, there is an all too easy transition between a desperate invitation to receive help and a conclusion that help will never come-- between little or no intent to die and a higher intent to die. Punishing suicidal thoughts or actions as if they were an

improper way to invite help from others can be very dangerous. Punishment often has the opposite effect to that which is desired. Help with problems, as well as help in finding other ways to ask for that help, is far more likely to be effective in reducing suicidal behaviors.

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MYTH: A suicidal person clearly wants to die.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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MYTH: Once suicidal, a person is suicidal forever.

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

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

## **Warning Signs**

### How can you tell if someone is thinking about suicide?

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

- Previous Attempts - this may mean that the person is at a high risk to try again.
- Threats - these are often followed by suicide attempts. Take all threats seriously.
- Depression and hopelessness- be aware of the symptoms of depression and hopelessness that were presented earlier (HO 3, page 35).

- Changes In Personality or Behavior - such as sleeplessness; lost weight, or a tendency to withdraw.
- Preparations For Death - such as quickly putting affairs in order, giving away personal possessions, acquiring a means to commit suicide such as a gun, rope or knife.

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

### **Initial Response for All Personnel**

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

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

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

### **REFERRAL PROCEDURES (HO 5, page 39)**

#### **1. PREPARATION**

A. Identify helping resources available on post.

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

#### **2. FOLLOW THROUGH**

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

#### **3. WHAT NOT TO DO**

- Don't assume the person isn't the suicidal "type".
- Don't keep a deadly secret. Tell someone what you suspect.
- When speaking with them:
  - Don't act shocked at what the person tells you.

- Don't argue or try to reason. Don't debate the morality of self-destruction or talk about how it might hurt others. This may induce more guilt.
- Don't analyze the person's motives. "You just feel bad because..."
- Don't try to shock or challenge the person. "Go ahead and do it." (This only works in the movies!)

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

Remember, Your mission is to encourage help-seeking behavior and to understand the Buddy Care principles in this training module, so that you can get help for any person who is in need. We are involved in a "full court press" to minimize suicidal behavior in the Army. (OH 10)

## **Handout 2**

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

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

- A bad evaluation for an enlisted soldier or officer.
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- Leaving old friends.
- Being alone with concerns about self and family.
- Financial stressors.
- New military assignments.
- Recent interpersonal losses.
- Loss of self-esteem/status.
- Humiliation.
- Rejection (e.g., job, promotion, boy/girlfriend).
- Disciplinary or legal difficulty.
- Exposure to suicide of friend or family member.
- Discharge from treatment or from service.
- Retirement.

### **Handout 3**

#### **What Are Common Symptoms Of Hopelessness and Depression**

##### **Hopelessness:**

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

##### **Depression:**

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

## **Handout 4**

### **Myths and Facts**

MYTH: Most suicides occur with little or no warning.

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

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

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**Handout 4, con't.**

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

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

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

**Handout 4, con't.**

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

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

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

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

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

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

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MYTH: Once suicidal, a person is suicidal forever.

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

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

## Handout 5

### Warning Signs

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

#### Feelings:

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

#### Actions

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

#### Change

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

#### Threats

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

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

## Handout 6

### Referral Procedures

#### 1. PREPARATION

A. Identify helping resources available on post.

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

#### 2. FOLLOW THROUGH

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

#### 3. WHAT NOT TO DO

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

## **GATEKEEPER LESSON 2**

### **Lesson Plan Advance Sheet**

**Title:** Suicide Prevention: Taking Appropriate Action

**Time:** 1 hour

**Target Audience:** Officers/NCOs (OH 1)

**The Mission:** The Army Suicide Prevention Program is based on trained and ready personnel at all levels. Our mission is to encourage help-seeking behavior and to attain proficiency in the principles of this training module. (OH 2) The Officers and NCOs are vital to the success of the Army Suicide Prevention Program. (OH3)

#### **Terminal Individual Objective**

Task: Provide supportive initial response to suicidal individual.

#### **Learning Objectives (OH 4)**

Participants will be able to:

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

#### **Soldier Preparation**

Gatekeeper Lesson 1

#### **Instructional Procedures**

Conference, role-plays.

## INSTRUCTOR NOTES

*Instructor Note:* Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. You must assume that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Also, you will seek to motivate members of the unit to become concerned for the well-being of friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

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

### INITIAL RESPONSE

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

**They bring up suicide: Direct Statements or Threats (OH 5 a-c).** If someone is talking directly about suicide:

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

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

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

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

If you spot warning signs or have some other reason for concern, you may have to share your concerns with the person. *If there is time*, and you do not wish to talk to the person, you may raise your concerns with the chaplain or a mental health professional. Here is one way to inquire about suicide (OH 6 a, b):

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

### Things to Avoid:

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

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

Remember, The Officer/NCO mission is to encourage help-seeking behavior and to be ready to obtain help for any person who is in need. We are involved in a "full court press" to minimize suicidal behavior in the Army. (OH 7)

## HANDLING TELEPHONE CALLS (HO 7, PAGE 48)

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

1. Establish a relationship with the person:
  - Quickly reinforce the person for having called or confided in you.
  - Be accepting, non-judgmental, warm, friendly, and supportive.
  - Although you may be feeling nervous, exude confidence and concern.
  - Let the person know you are willing to help, that you care for them as a person.
  
2. Gather information:
  - Get as much information as possible and find out specifically where the person is.
  - If someone else is there, get him or her to make the other calls. Get an address and call the military or civilian police first.
  - Always call the military or civilian police in a situation where danger of suicide is high and the person is not in a controlled situation, such as in the company of friends or loved ones.
  - You may be the only person available to help. In order to make other calls to gather and mobilize the suicidal person's resources, you may have to end your conversation with him or her.
  - If so, be certain they understand why you need to end the telephone call. Tell them that you will call them back shortly after you have obtained the required assistance.
  - You may call a chaplain, clergy person or obtain the help of paramedics, police, military police, or others. Let the person know who you have obtained help from.

## ROLE PLAYS

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

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

### SCENARIO #1 (HO 8, page 49)

#### PROBLEM:

A friend tells you about a fellow soldier who is away at a major field exercise, deployment, or other reason for the first time. The friend becomes very anxious over his failure to be successful. He breaks up with his girlfriend and begins drinking and using drugs. He talks about being a burden to his friends and a disappointment to his family and unit. You know he recently tried to

buy a pistol, saying it was a gift for his father. What do these signs suggest and what would you do about them?

ALLOW TIME FOR DISCUSSION (about 10-15 minutes)

#### DISCUSSION LEADER'S CHECK LIST:

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

#### WHAT TO DO:

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

#### SCENARIO #2 (HO 8, page 49)

#### PROBLEM:

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

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

ALLOW TIME FOR DISCUSSION (about 10-15 minutes)

#### DISCUSSION LEADER'S CHECKLIST

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

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

These signs are particularly suggestive of suicidal depression.

**WHAT TO DO**

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

**SCENARIO #3 (HO 8, page 49)****PROBLEM:**

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

ALLOW TIME FOR DISCUSSION (about 10-15 minutes)

**DISCUSSION LEADER'S CHECKLIST:**

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

**WHAT TO DO:**

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

**Handout 7,****HANDLING TELEPHONE CALLS**

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

1. Establish a relationship with the person:

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

## 2. Gather information:

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

## Handout 8

### SCENARIO #1

#### PROBLEM:

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

### SCENARIO #2

#### PROBLEM:

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

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

### SCENARIO #3

#### PROBLEM:

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

## **GATEKEEPER LESSON 3**

### **Lesson Plan Advance Sheet**

**Title:** Suicide Prevention: Assessing Risk

**Time:** 2 hours

**Target Audience:** Formal Gatekeepers (OH 1)

#### **Terminal Individual Objective**

Task: Assess Risk for Suicide

**The Mission:** The Army Suicide Prevention Program (ASPP) is based on trained and ready personnel at all levels. Our mission is to encourage help-seeking behavior and to attain proficiency in the principles of this training module. (OH 2) The Formal Gatekeepers of our community helping agencies are vital to the success of the ASPP. (OH3)

#### **Learning Objectives (OH 4)**

Participants will be able to:

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

#### **Soldier Preparation**

Gatekeeper Lessons 1 & 2

#### **Instructional Procedures**

Conference.

**Instructor Note:** This lesson contains materials that supplement those of Gatekeeper Lessons 1 & 2, pages 23-49

In summary, it is proposed that:

- Gatekeeper Lesson 1: All service personnel should be trained to encourage help-seeking behavior and to perform “Buddy Care.”
- Gatekeeper Lesson 2: Leaders to whom soldiers may come or refer others to for help must be able to inquire about suicide, and obtain formal help for at-risk individuals.

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

### Instructor's Notes

*Instructor Note:* Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. You must assume that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Also, you will seek to motivate members of the unit to become concerned for the well-being of friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

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

### Risk Factors

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

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

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

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

## Risk Assessment

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

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

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

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

### Risk Assessment Questions (OH 5 a-c):

QUESTION #1 Have you been thinking of killing yourself?

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

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

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

QUESTION #3 How will you do it?

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

QUESTION #4 How much do you want to die?

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

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

**QUESTION #5** How much do you want to live?

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

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

**QUESTION #6** How often do you have these thoughts?

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

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

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

**QUESTION #8** Have you ever attempted suicide?

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

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

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

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

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

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

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

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

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

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

Remember, The Formal Gatekeeper mission is to encourage help-seeking behavior, to perform intervention screening, and to obtain help for any person who is in need. We are involved in a "full court press" to minimize suicidal behavior in the Army. (OH 6)

## Handout 9

### Risk Factors

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