

SUICIDE PREVENTION TRAINING

Introduction

Sailors and Marines can make a significant difference in preventing suicide and suicidal behaviors among their Shipmates and fellow Marines. This training offers proactive steps for taking care of each other to prevent suicide within the entire Navy and Marine Corps community--from civilians to active duty personnel and from the enlisted ranks to officers. Navy Family Service Centers, Marine Corps Community Service Centers, Chaplains, and Medical Treatment Facilities stand by ready to assist commands in presenting Suicide Prevention training. All Sailors and Marines need to know about suicide prevention and strategies for getting early assistance prior to escalation of personal problems. Early intervention helps; it doesn't hurt. Problems left unattended can spiral out of control.

By a ratio of 3 to 2, more people in the United States die by suicide each year than by homicide. Approximately a half-million people are admitted to emergency rooms each year due to suicide attempts. Suicide knows no special boundaries of age, race, or sex. Although males are at highest risk for completed suicides, females are twice as likely to report a past history of suicide attempts. As a reflection of society, the military is also affected by suicide.

In response to this killer, the Surgeon General of the United States has declared the problem of suicide a serious public health threat. He issued a *Call to Action* (1999) to develop strategies to prevent suicide and the suffering that it causes.

Navy and Marine Corps have joined forces to develop a strategy for the Department of the Navy (DON). This strategy emphasizes the synergy of the entire Navy and Marine Corps community--leaders, co-workers, peers, counselors, medical providers, chaplains, and family members--in suicide prevention.

Following the recommendations of subject experts from the American Association of Suicidology, Navy Personnel Command, and Headquarters Marine Corps, the Secretary of the Navy in Aug 1998 approved a plan to develop a best-practice approach to suicide prevention. This training package is one result of this collaborative effort. The DON suicide prevention effort seeks to use evidence-based interventions with three aims: reducing modifiable risk factors, strengthening protective factors, and training Sailors and Marines in how to respond to suicide risk

among their Shipmates and fellow Marines.

Training Objectives

- **Raise awareness in Navy and Marine Corps about the problem of suicide**
- **Teach personnel to identify warning signs of suicide**
- **Instruct members in their duties as “first responders” using the acronym AID LIFE**
- **Identify and promote protective factors**
- **Describe local assistance resources and how to access them through the Chain of Command**

The DON Suicide Prevention Training Course is for the entire Navy and Marine Corps community, and it can be completed within a sixty-minute time frame. The presentation is to be made by a prepared facilitator using the components of this course packet: the Suicide Prevention video, overhead slides, and this manual.

About the Video

This 19-minute professionally produced video combines narration and scenarios to illustrate practical ways to intervene with people at risk for suicide. This video is for all hands, regardless of age or rank.

The media sometimes glamorizes suicide or gives undue attention to suicidal behavior. Sailors and Marines who are guided by our core values should understand that there is no honor in suicide. Consequently, this video does not dwell on dramatic portrayals of people attempting suicide or focus on disturbing statistics. Military leaders and national experts worked together to develop scenes that focus on the people who first recognize the threat or risk of suicide and immediately respond to prevent the possibility of a suicide. Shipmates and fellow Marines who consider suicide need help. Specific steps were taken in this video to highlight positive role models of all ranks who take morally courageous steps to prevent suicide. These heroes are called “first responders.”

The video is built around the twin themes that, as Sailors and Marines, “we take care of each other” and “it’s OK to get help.” The video emphasizes the principles of community action and teamwork to prevent problems that detract from individual and unit readiness. The training uses the acronym *AID LIFE* (see Section I) to provide

practical steps to take care of each other and prevent suicide.

In some of the scenes the risk for suicide is clear, while in other scenes the threat is subtle. All scenes depict fairly common situations that afford opportunities for Sailors and Marines to take action. Here's a quick overview of the scenes as they unfold in the video:

Scenario 1: A Sailor deals with a Shipmate who is not coping well with the rigors of training school.

Scenario 2: A Marine Colonel responds to an officer who is despondent following failure to select for promotion.

Scenario 3: A Sergeant confronts a Lance Corporal for showing impulsive anger in deriding a co-worker. The Lance Corporal began inappropriately displaying his anger after finding out that his girlfriend had decided to break off their relationship.

Scenario 4: A Chief uses his Chain of Command to assist a Petty Officer who is facing serious legal and emotional repercussions following a DUI charge, and mounting alcohol abuse and marital problems.

Scenario 5: A Marine Company Commander, Staff Sergeant, and Chaplain work together to help a Marine facing disciplinary action.

These scenes portray people facing perceived or real failures, dealing with emotional losses, or confronting the hard reality of consequences for impulsive or reckless behavior. The scenarios illustrate that it is our duty to seek appropriate assistance for our fellow Shipmates and Marines—no matter what their situation. Whether problems are personal, legal, or administrative, getting assistance provides opportunities to broaden emotional resources and abilities to cope with a current crisis. This training does not minimize a person's responsibility for his or her behavior and for seeking help. Real prevention occurs when help is obtained early, before a situation spirals out of control. However, it is never too late to get assistance. Remember that a life may be saved by getting a Shipmate or fellow Marine the professional help he or she needs.

About This Manual

Who is it for?

This manual was written to provide assistance to course facilitators in presenting the training video and course content. It provides facilitators with guidelines to explain a basic model of suicide prevention, risk, and protective factors; to respond to frequently asked questions (FAQ's) about suicide; and to enhance effective group discussion.

How is the manual organized?

The manual is organized into seven sections.

Section I briefly defines and explains terms and the acronym specific to the video:

- First Responder
- *AID LIFE*

Section II offers a format for presenting the training:

- Methods for Training
- General Outline
- Materials/Equipment Needed
- Transparency Titles
- Lecture Notes
- Video Training
- Discussion and Review Information

Section III presents background information:

- The Problem of Suicide
- A Model for Understanding Suicide
- Warning Signs for Suicide: Risk Factors
- Protective Factors and How to Promote Them

Section IV describes potential assistance resources:

- Local Resources to Assist in Suicide Prevention

Section V presents common questions and answers:

- Frequently Asked Questions (FAQ's) About Suicide

Section VI offers core principles of adult learning and strategies to engage small groups in active and effective interactive discussion. These are offered as

- Six Tips for Effective Facilitation

Section VII offers a brief Bibliography for further reading to enhance facilitators' understanding of suicide and suicide prevention.

What Should It Help You Do?

The manual should help you better understand the problem of suicide and guide you in how to use group discussion to bolster the information presented in the video. It may serve as a map and a primer, providing sufficient information and resources to make the teaching of course objectives easier.

What Does the Manual Not Do?

No manual, particularly one this brief, can present fully what one needs to know to be an expert, in this case a suicidologist. Many texts and considerable experience would need to be mastered for an instructor to be sufficiently accomplished and knowledgeable to handle any and all situations and questions. While an attempt has been made to anticipate and answer most FAQ's, surely there will be many that are beyond the scope of what is presented here. This manual emphasizes clarity and brevity rather than detail. More thorough understandings must be sought in other resources (see Section VII). The goal was to keep this manual user-friendly and to facilitate effective teaching, not to create a textbook.

Similarly, this manual does not cover all suicide prevention strategies. It is specific to the early detection and referral approach depicted in the video.

One word of caution: Information presented in a hard copy manual can never stay current with changing military resources. This manual contains information on potential local resources and how to access them. Unfortunately, it is possible that such information may be outdated even before it is read. Information on locally available sources for assistance should be validated as correct *before* being shared with those attending the Suicide Prevention course.

SECTION I. Definitions

Two core concepts are defined and explained here. The first is one of the essential course objectives: instructing all Sailors and Marines in the duties of the *first responder* in dealing with suicide risk among Shipmates and fellow Marines. It is what we do. We take care of each other. The second is the acronym *AID LIFE*, first used by the U.S Army Center for Health Promotion and Preventive Medicine.

Who is a "First Responder"?

A *first responder* is a person who first *recognizes* the threat or risk of suicide *and responds* to prevent the possibility of a suicide. A synonym for first responder is *gatekeeper*. A first responder or gatekeeper is a member of the military community who observes that someone is in trouble, in this case possibly suicidal, and refers that person to sources of help. A first responder could be anyone--a supervisor, Officer on Duty (OOD), family member, Shipmate or fellow Marine.

Duties of First Responder

- Learning what to observe and the possible meanings of what is observed
- Adopting an attitude that "I can help"
- Understanding what to do
- Knowing where to get professional help from resources in the military and civilian communities

What does the acronym AID LIFE mean?

AID LIFE is offered as a tool to further first responders' understanding of the helping strategy offered in this course. ***AID LIFE*** also serves as a memory device to help first responders maintain an awareness of the essential steps--the "what to do" -outlined in this program. ***AID LIFE*** stands for:

A: Ask. Do not be afraid to ask, "Are you thinking about hurting yourself?" or "Are you thinking about suicide?"

I: Intervene immediately. Take action. Listen and let the person know he or she is not alone.

D: Don't keep it a secret.

L: Locate help. Seek out the Officer on Duty, chaplain, physician, corpsman, friend, family member, crisis line worker, or emergency room staff.

I: Inform the Chain of Command of the situation. The Chain of Command can secure necessary assistance resources for the long term. Suicide risk does not get better with quick solutions. Effective problem-solving takes time, and the Chain of Command can monitor progress to help avert future difficulties.

F: Find someone to stay with the person now. Don't leave the person alone.

E: Expedite. Get help now. An at-risk person needs immediate attention from professional caregivers.

SECTION II. Presenting the Training

Method for Training

This training should be presented in a multi-media format using a VCR and overhead transparencies. The presentation combines lecture, video training, and discussion to meet the stated learning objectives. While the video will usually be shown straight through, the facilitator may also choose to freeze-frame the video as needed to highlight specific teaching points or stimulate discussion.

General Outline

- Lecture with Transparencies
- Video Training
- Discussion and Review
- Description of Local Resources

Materials/Equipment Needed

- Training Video
- Overhead Slides
- Facilitator's Manual
- VCR/TV
- Overhead Projector
- Optional: Chalkboard, Flip Chart

Transparency (TP) Titles

- TP1** "Training Cover Slide/Logo"
- TP2** "Suicide: A Serious Public Health Threat"
- TP3** "Suicide Model"
- TP4** "First Responders"
- TP5** "Training Objectives"
- TP6** "About the Video Training"
- TP7** "Discussion Question 1"
- TP8** "Risk Factors/Warning Signs"
- TP9** "Protective Factors"
- TP10** "Discussion Question 2"
- TP11** "Positive Steps"
- TP12** "Discussion Question 3"
- TP13** "Discussion Question 4"
- TP14** "Local Helping Resources"
- TP15** "AID LIFE Review"
- TP16** "Summary/Review"

Lecture Notes and Transparencies

The following lecture notes are designed to be a guideline. It is important that the facilitator present this material in a comfortable manner that fits his or her style of effective presentation. Sections indicated in parentheses at the end of each lecture note paragraph should be carefully studied in advance. These provide additional resources and material to assist the facilitator's presentation.

1. Gain Attention [TP1 On]. "Good morning/afternoon. My name is _____. We're here today to talk about preventing suicide in Navy and Marine Corps. My plan is to give information to raise awareness about suicide and to facilitate discussion about the best ways to prevent suicide within the entire Navy and Marine Corps community." (Facilitator should review **Section VI** of this manual prior to presenting.)

[TP1 Off]

2. [TP2 On] "The U.S. Surgeon General has called suicide a serious public health

threat in our nation. Throughout our society, over 30,000 people a year take their own lives. By a ratio of 3 to 2, more people die by suicide each year than by homicide. Since the military is a reflection of society, suicide also affects Navy and Marine Corps. For the past 10 years, suicide has been either the second or third leading cause of death among active duty Sailors and Marines.” (See **Section III.**)
[TP2 Off]

3. [TP3 On] “One helpful model for understanding suicide emphasizes the role of mental health problems [point to the ‘Disorder’ box] such as depression, anxiety, and alcohol abuse in making people vulnerable to suicide. As shown by the next box, when these mental health problems are combined with stressors like relationship losses, or career, legal, or financial trouble, people’s moods can worsen to the point where they feel extreme anger, anxiety, hopelessness, or depression [point to the ‘Mood Change’ box]. If a person in this state of mind has access to a means for self-harm and feels isolated from others, the risk for suicide may be increased or facilitated. Additionally, if such a person doesn’t have strong beliefs against suicide or has had someone close to him or her commit suicide, the risk is also increased. On the other hand, if a person in this situation doesn’t have access to a means of self-harm and has strong beliefs against suicide, as well as the support of family members, friends, and helping professionals, the risk for suicide is decreased or inhibited.

“Every day people face a variety of stressors with no thought of suicide or self-destructive behavior. It’s not stress *per se* that makes a person suicidal. It’s the underlying psychological problems such as depression or alcohol abuse that affect a person’s thinking and judgment, and put a person at risk for suicide. Suicidal thinking is not a normal response to stress. That’s why we have to act to get help for suicidal people before it’s too late. The good news is that effective treatments for depression and other mental health problems are readily available.” (See **Section III.**)
[TP3 Off]

4. [TP4 On] “During this training we will talk about practical ways to help people at risk for suicide. Our focus is on training you to be a *first responder*, a person who recognizes someone at risk for suicide and takes action to help someone in need. First responders can be Shipmates, fellow Marines, coworkers, supervisors, friends, or family members.” (See **Section I.**)

[TP4 Off]

5. [TP5 On] “To increase your skill at being a first responder, we have some specific **training objectives**. At the close of this training you will be able to do the following [point to each bullet as it is mentioned]:

- Describe warning signs for suicide
- I identify protective factors
- Use the acronym A I D L I F E to recall 7 action steps
- Discuss positive characteristics of first responders
- I identify local resources for help and support”

[TP5 Off]

Video Training

6. [TP6 On] “This training is a joint Navy and Marine Corps project and combines lecture, video training, and discussion. We don’t expect you to become suicide experts through this training, but we do want you to leave here confident that you can do something to help.

“We’re now going to view a video called *Suicide Prevention: Taking Action – Saving Lives*. Two narrators, a Navy Chief Petty Officer and a Marine Master Sergeant, will lead us through basic information about suicide and typical scenarios where Sailors and Marines can take action as first responders.

“In some cases, the risk is obvious, in others less so. In all cases, first responders must exercise moral courage to take action. We’re not going to say it’s easy. It’s not--but taking action to prevent suicide is the right thing to do. After the video is over, we’ll discuss the key points to ensure everyone knows what to do.” (See **Manual Introduction**.)

[TP6 Off] *PLAY THE VIDEO.*

Discussion and Review

7. [TP7 On—Discussion Question 1] “Now that you’ve seen the video, let’s talk about it. What were some risk factors or warning signs for suicide portrayed in the video?” (See **Section III**.)

[TP7 Off]

8. [TP8 On] “As mentioned, risk factors are characteristics that describe people who could be at risk for suicide. Stress alone rarely causes suicide. Rather it is the presence of an underlying mental health problem that can result in a mood change and suicidal behavior.

“There are three key risk factors for suicide: (1) mental health problems such as depression and/or alcohol abuse, (2) suicidal thoughts—which are often hinted at or discussed with others, and (3) a previous suicide attempt.

“These key factors may occur with the other behaviors commonly associated with suicide. These problems include relationship difficulties, impulsive anger and behavior, legal troubles, social isolation, and work performance difficulties.

“Such behaviors are common signs pointing to either serious personal problems or suicidal risk. These common signs are indications that professional assistance may be required. If assistance is provided early, then more serious problems, such as suicide attempts, can be avoided.” (See **Section III.**)

[TP8 Off]

9. [TP9 On] “Just as there are risk factors for suicide, there are protective factors that can help keep people from reaching a suicidal crisis. These protective factors include: acceptance and support from others, handling problems before they escalate into crises, healthy lifestyles and good coping skills, a belief that it’s OK to get help, spiritual support, and strong cultural and religious beliefs against suicide. By reducing risk factors and by strengthening protective factors, we can help prevent the problems that contribute to suicide.” (See **Section III.**)

[TP9 Off]

10. [TP10 On—Discussion Question 2] “Let’s return to our discussion of the video. What were some examples of positive actions that first responders took to help?”

[TP 10 Off]

11. After a short period of discussion, place TP11 on the projector to summarize “Positive Steps” by First Responders. Review a few key steps from this transparency and then move on to the next one.

[TP11 Off]

12. [TP12 On—Discussion Question 3] “As we just said, the video gives examples of positive actions to help. But things in real life are never easy; what are some barriers, such as attitudes or problems, that first responders might face in these situations?” (Note to Facilitators: Don’t let this question serve as a starting point for a gripe session, but use the discussion to acknowledge that attitudinal barriers such as mental health stigma do exist and need to be addressed). “What can you do to overcome these barriers?”

[TP12 Off]

13. [TP13 On--Discussion Question 4] “What helping resources did you see in the scenarios?” (Helping resources in the video include first responders, command representatives, chaplains, and mental health providers.) “Are there other resources, not necessarily from the video, that you think we should mention?” (See **Section IV.**)

[TP13 Off]

Possible Local Assistance Resources

14. [TP14 On] “Here is information about resources in our area.” (See **Section IV.**)

Important Note to Facilitators: This slide serves as a template for services available throughout Navy and Marine Corps. Make sure you obtain updated information about accessing these resources *before the presentation*. It is important that the information be correct so that Sailors’ or Marines’ duties in responding to suicide threats are not complicated by inaccurate local information. Information on your local resources needs to be current and accurate. (See **Section IV.**)

[TP14 Off]

15. [TP15 On] “Let’s review the action steps that are part of AID LIFE. What do the letters stand for?” (One technique might be to cover the steps on the transparency until they are identified during the discussion.) (See **Section IV.**)

[TP15 Off]

16. [TP16 On] "This slide recaps the topics we've covered. We've discussed suicide warning signs and protective factors. We've talked about what it means to be a first responder and how people can access local resources for help. We also used the acronym AID LIFE to outline positive action steps. As we wrap up, remember that responding to suicidal behavior in a Shipmate or fellow Marine is a rescue action. By working together we can save lives and make a real difference in preventing suicide in Navy and Marine Corps."

SECTION III. Suicide, Suicide Risk, and Suicide Prevention

The Problem of Suicide

Suicide is an intentional act resulting in one's own death. *Suicidal behaviors* encompass a broad range of acts, including suicidal attempts, gestures, threats, and suicidal thoughts. Suicide attempts are behaviors that if left unchecked could result in death. Suicide gestures are defined as behavior that would not result in death if left unattended. The lack of lethality does not undercut the seriousness of suicidal gestures. Lethality of a behavior does not necessarily coincide with whether or not the person intends to end his or her life. A suicidal person does not always understand what is lethal and what is not. For instance, in the case of overdoses, he or she does not always know what dosage will result in death. The only solution for first responders is to take all suicidal attempts, gestures, and threats seriously.

In the United States suicide ranks among the top ten causes of death (it was eighth in 1997). It is even more common among males than females and most common among white males. However, as stated in the Introduction, practically anyone is capable of thinking of, threatening, attempting, or completing suicide--assuming they feel enough pain or distress.

Each year in the United States there are approximately 30,000 suicides. We do not know the actual number of attempts or threats that are made, or the number of persons who think about suicide. However, there have been reliable surveys administered by the Centers for Disease Control to younger (high school age) populations that suggest the following percentages:

Suicidal thoughts: about 20% in any year

Suicidal thoughts with a plan: about 16% in any year

Suicide attempts: about 8% in any year

Suicide attempts requiring medical treatment: about 2-3% in any year

Navy and Marine Corps suicide rates are lower than civilian rates when matched for gender, age, and racial differences. The reasons for this have a lot to do with the specific requirements for fitness for duty and the natural social support that exists in the Services. Given that service members undergo screenings, have regular employment and supervision, and have access to medical and treatment services, it is not surprising the military population has lower suicide rates than the civilian population. However, the problem of suicide is not easily eliminated. Suicide is still one of the top killers of Sailors and Marines. It is only when we all accept our responsibility for looking out for those in need that we can stop this preventable cause of death in our communities.

The biggest reason people threaten suicide or communicate to others they have been thinking about suicide--and the great majority do so before attempting or completing suicide--is to let others know they are in pain or great psychological distress. It is their way to let it be known that they need help. We cannot predict whether they might kill (or attempt to kill) themselves once they have the thought of suicide. However, we can be sure that if we ignore such communications, we increase the chances that someone in pain will feel even worse (unnoticed, uncared for, unheard) and have even more reason to want to end that pain by suicide.

Pain felt by someone who may be suicidal often is related to unmet needs. We all have needs to be loved, to be in control, to avoid shame. Suicidal thoughts can be brought on by an event or series of events best characterized as a loss or threatened loss (e.g., a relationship breakup, a failure, a humiliation). Yet the fact remains that we all have failed relationships and failures, so it is important to keep in mind that such simple explanations are inadequate to account for the complicated nature of human behavior—especially when someone is in a personal crisis.

Quite often, the psychological pain a suicidal person feels is intensified by an underlying mental health problem, such as depression or anxiety. Sometimes, persons in such despair try to cope with their pain by turning to alcohol or drugs to deaden the emotional pain. Of course, the consequence of this is only to make their problems

(and pain) worse. But there is no typical description of someone who is suicidal. Because suicide is such a complex behavior, it requires a trained professional to understand, evaluate, and effectively treat what is likely to be a serious mental health problem. For this reason, the basic message of this Suicide Prevention training is to observe, identify, and refer for help.

A Model for Understanding Suicide

Research in the area of suicide has led to the creation of a model for understanding suicide. Theoretical models help us understand behaviors and problems, though no model perfectly represents a complex phenomenon. The slide presentation (Transparency 3) offers a model by Dr. David Shaffer about suicide. A good model gives us a mental picture that translates complexity into key concepts and themes. In other words, a model can be a roadmap, helping us see the terrain and plot out a reasonable strategy for reaching our destination, that is, to prevent suicide.

In this model, mental health difficulties result in vulnerability for suicide. Suicide risk increases when there is a precipitating event that affects someone who is at risk, and when these events and risk factors are not sufficiently balanced or counteracted by protective factors.

A key point that follows from an understanding of this model is that getting help early may prevent suicide.

This Suicide Prevention training is not training in medical treatment or psychotherapy. However, professional assistance cannot begin unless the people at risk seek help--or are observed and referred for help before they attempt to end their problems by suicide. Because almost three-quarters of persons thinking about suicide tell others what they are considering or planning, there is plenty of opportunity to be a first responder and to begin a helpful intervention. With such a large proportion of people who discuss their suicidal intent, it seems safe to assume that most want to be helped, rather than to die.

This training focuses on increasing understanding of the warning signs for suicide, the role that stress can play in triggering suicidal behavior, and the protective factors that decrease the risk for suicide.

Warning Signs of Suicide

Research shows that a predisposition for suicide is rooted in pre-existing mental health problems such as depression and substance abuse. Suicidal behavior stems from a complex interaction among psychological and situational factors. Signs of vulnerability for suicidal behavior are seen as “key risk factors.” These warning signs or “red flags” call our attention to the potential for suicide or suicidal behavior. The great majority of people with each of the following warning signs will not act to harm themselves. Yet each of these alerts us that they might. Each occurs more often in the lives of those that harm or kill themselves than among those who do not. Getting assistance early helps. It does not hurt. *With or without a current threat of suicide*, people with the following signs and symptoms need assistance.

Key suicide risk factors

- Mental health problems such as depression and substance abuse. A family history of depression or substance abuse can also elevate a person’s risk.
- Talk or hints of suicidal intent
- Previous history of suicidal threats and attempts

Depressive Symptoms

Depression often plays a significant role in suicide and can be indicated by

- Difficulty concentrating or remembering, indecisiveness
- Loss of interest in or enjoyment of usually pleasurable activities
- Loss of energy, fatigue, slowed speech and muscle movement
- Decreased productivity, poor performance
- Expressed feelings of inadequacy, worthlessness, or low self-esteem
- Change in sleep habits to too little or to a desire to sleep all the time
- Pessimism about the future, negative thoughts about the past
- No apparent pleasure in response to praise or rewards
- Tearfulness or crying
- Change in appetite, unwanted weight loss or weight gain
- Recurrent thoughts of death or suicide
- Decreased sex drive

The good news is that effective treatments for depression such as antidepressant medication and psychotherapy are readily available.

Other common warning signs

- Preoccupation with death
- Giving away possessions
- Relationship difficulties, including a recent loss or threat of significant loss
- Impulsive anger and behavior
- Legal or financial trouble
- Isolation and withdrawal from friends and family, social isolation, a sense of intolerable aloneness
- Performance difficulties
- Inability or unwillingness to connect with potential helpers

Stress Events

These are the “triggers,” or final straws that break the proverbial camel's back (e.g., a threatened separation or end of relationship, a humiliation, a failure, a disciplinary crisis). In some cases, the stressors that precede a suicide may seem to most people to be common problems rather than exceptional difficulties. Such stressors may appear overwhelming to a person with an underlying psychiatric condition such as depression or alcohol abuse.

Protective Factors

These provide protection to lessen the risk of suicidal behavior. Protective factors can be described on different levels ranging from the individual to peer group, all the way to the entire Navy and Marine Corps community. These include good problem-solving skills, reasonable expectations, an ability to tolerate failure and move forward to new challenges, social acceptance, support from others, and unit cohesion. For each of these there may be specific actions that each of us can take to help build an environment that respects and protects emotional health, and supports individual and unit readiness (see **Table 1**).

Protective Factors Decreasing Risk of Suicide

- unit cohesion/camaraderie/social support
- access to counseling and treatment services
- involvement in the community life of Navy or Marine Corps (e.g., volunteer work)
- a sense of reward in serving the mission of the command
- the feeling of being supported in times of need (and being able to seek help and have help available when it is sought)

- effective problem-solving and coping skills
- spiritual support
- cultural and religious beliefs against suicide and in support of self-preservation

TABLE 1. Protective Factors and How to Promote Them

Level	Protective Factor	How to Promote Factor
Individual	Sense of control/effective coping skills/optimistic outlook	<ul style="list-style-type: none"> • Keep the focus on succeeding and accomplishing the mission • Provide life skills training to enhance personal problem-solving and coping • Remind others of their own success, competence, and mastery
Peers	Acceptance and support	<ul style="list-style-type: none"> • Promote unit cohesion and camaraderie • Recognize achievements
Community/ Command	social support/ positive attitude about getting help early	<ul style="list-style-type: none"> • Promote social involvement • Make it known that helping resources exist • Handle problems early • Offer user-friendly access to helping resources • Emphasize "It's OK to get help" • Work to destigmatize counseling and mental health care • Communicate clear messages against suicide

Other important concerns

Potential for Combined Homicide and Suicide

Research shows there is a specific group of risk factors associated with murder-suicides. Usually both the murder and the suicide are premeditated. The suicide typically occurs within a week of the murder. Nationally, men perpetrate the majority of murder-suicides with motivations of intense jealousy and fear of losing a relationship that, to the perpetrator, appears to be deteriorating. Other, less common perpetrators include depressed mothers and despairing elderly men with ailing spouses. Navy typically has one to two murder-suicides per year. Marine Corps has fewer incidents due to the Service's smaller endstrength, with about one incident within a two-year period. Murder-suicides among Navy and Marine Corps members typically are carried out by men who are experiencing intense jealousy and fear of losing a significant relationship. National murder-suicides rates are typically between 0.2 and 0.3 per 100,000. Frequency of murder-suicides in Navy and Marine Corps is within the national norms.

Workplace Violence and Suicide

Workplace violence culminating in suicide is rare in Navy and Marine Corps. These incidents occur so seldom that it would be difficult to determine accurate rates or patterns of occurrence. People who have a history of violent, threatening and other disruptive behavior are more likely to display this behavior in the workplace. The following statements could indicate a predisposition toward workplace violence: expressing fascination with incidents of workplace violence, indicating approval of the use of violence to resolve personal problems, or identifying with perpetrators of workplace violence. When these statements occur they should not be ignored—especially in combination with a history of substance abuse and/or statements of desperation over family, financial, and other personal problems. This combination of factors indicates good reason for further supervisor involvement, or professional evaluation of the risk for suicide and/or violence.

Section IV. Resources in Suicide Prevention

A multidisciplinary team including Navy and Marine leaders, medical providers, chaplains, Family Service Center and Marine Corps Community Services counselors, and Substance Abuse counselors is available to support a community approach to suicide prevention within the DON. **Table 2** provides an overview of resources that can assist in suicide prevention by addressing risk factors and by promoting

protective factors (see **Table 1**). As part of a proactive approach to prevention, ensure current information is kept on hand concerning how to access helping resources.

Table 2. Suicide Prevention Resources

Program Elements	Specific Resources
AWARENESS EDUCATION	<ul style="list-style-type: none"> - Headquarters Messages (NAVADMI NS, ALMARS) - Prevention training for all personnel - Command leadership
LIFE SKILLS TRAINING	<ul style="list-style-type: none"> - Alcohol and drug abuse prevention training - Stress management training - Anger management training - Chaplain's Religious Enrichment Development Operation (CREDO) - Communication and conflict resolution training
LEADERSHIP TRAINING	<ul style="list-style-type: none"> - Senior program briefs - Suicide Prevention training in leadership and formal schools
COUNSELING/ TREATMENT SERVICES	<ul style="list-style-type: none"> - Family Service Centers/ Marine Corps Community Services (Personal Services) - Chaplains - Mental Health Services at clinics and hospitals
PROTECTING THE SURVIVORS OF SUICIDE WITHIN COMMANDS & FAMILIES (Postvention)	<ul style="list-style-type: none"> - Sensitive family support by Casualty Assistance Calls Officer (CACO) and Chaplains - Command post-suicide interventions - Special Psychiatric Rapid Intervention Teams (SPRINT) - Critical Incident Stress Debriefing (CISD)

Section V. Frequently Asked Questions about Suicide (FAQ's)

The facilitator should be familiar with the material contained in the answers to all FAQ's. These questions and concerns are often raised during suicide prevention training. One presentation strategy could be to discuss each of the following questions during the presentation to be sure to address unspoken concerns.

1) How do I tell if someone is *really* thinking about suicide?

Because we cannot read minds, it is not possible to determine what someone is really thinking. It is better to rephrase the question as follows: "How do I tell if a person is at risk for suicide?" The answer to this question is addressed by the items outlined in the slide about suicide warning signs. Notice others and be aware that these signs may be present in people you might never have thought would be suicidal. If you have any thought that suicide might be an issue, AID LIFE by asking the person directly and/or seek the counsel of someone in the Chain of Command.

2) What if I am worried about someone who is not in my unit or whom I do not know very well?

Effective responding requires a constructive working relationship between helper and the person in crisis. It would be best to take your concerns to a friend or superior of that individual. Tell someone who may be able to approach the person directly and better evaluate whether an intervention is needed. Do not keep your concerns or observations secret. Your willingness to help may save a life!

3) As a facilitator, what should I do if someone comes up to me and says, "I'm considering suicide"?

While such an occurrence is rare, you should be prepared for this to happen. You also should expect to be approached by persons upset about suicide because they are survivors, that is, individuals who have experienced the tragedy of a suicide by someone close or important to them. Be ready for these possibilities. **As a facilitator, you must have a pre-planned response set up** with local medical providers to handle this possibility.

A facilitator needs to have the comfort, confidence, and competence to offer needed help. No facilitator should ever do anything he or she does not feel confident in undertaking. At a minimum, the facilitator should feel qualified to apply the AID LIFE acronym. In this situation, you can praise the individual for having the courage to speak up, and tell him or her that this is the first step toward better days. You are then the first responder who can connect the individual with someone in a position to help (the person identified for referrals, as noted in previous paragraph).

4) Where is the best place to go for help?

Every Command should have the support services of a chaplain, corpsman, physician, or mental health provider who can ensure that the person is properly evaluated. If you are away from the Command, use a local emergency room and call the Officer on Duty to keep the Chain of Command informed about the situation.

5) I tried to get help for/from someone in the past and had a bad experience.

For the benefit of others in the audience, remark, "This is an unfortunate, but unusual, situation. Most people who go for help benefit significantly from the experience."

Then ask how recent this was and whether help is still needed. Listen carefully and offer to assist if needed. Encourage the person to give feedback to the agency or helper involved. Offer to assist in this process. Feedback is one way to assure a quality response, and can help in avoiding future problems or clearing up confusion and misunderstanding.

6) Who is the typical Sailor or Marine who completes suicide?

Most suicides occur among white males under 30 in the enlisted ranks. Typically, the person who dies by suicide is in a leave or liberty status and dies in CONUS. Keep in mind, however, that suicide risk can be found in all ranks, in both genders, and across all races.

7) I know someone who killed himself/herself and there were no warning signs.

Situations like this can happen, but in the overwhelming number of cases people exhibit some warning signs or talk about their feelings of depression and hopelessness. Studies show that, with very few exceptions, suicidal individuals have/had a significant history of emotional and interpersonal difficulties. We might not always be able to notice the warning signs, but this should not stop us from trying.

8) How do I know I am not damaging someone's career by getting help for him or her?

Actually, not getting help is much more likely to damage a career. Emotional problems left unattended result in problem behaviors. The longer someone goes without assistance, the more likely something will occur that could be career-damaging. The sooner you get someone assistance, the sooner he or she can have the help that keeps that person's life and career on track.

For example, overuse of alcohol often leads to impulsive behaviors, increased aggression, possibly even a DUI. Repeated alcohol-related incidents end careers. Let's illustrate this by considering someone with a severe drinking problem. The person's friends are most likely to know that he or she has a drinking problem. These friends can get the person the help needed before a DUI occurs. Keep in mind that trying to safeguard someone's career may cost the person's life (by suicide) or someone else's life (by a DUI).

9) What if I ask someone if he or she is thinking about suicide when he or she hasn't thought of it? Will that make the person go out and do it?

No more so than asking if a person smokes cigarettes would cause him or her to start smoking. By asking, you are letting a person who may be thinking of suicide (or having other problems) know that you are willing and interested to hear about his or her thoughts. Talking about feelings promotes understanding and can greatly reduce distress. If a person is feeling suicidal, it can come as a great relief to find someone else cares about how he or she feels. In contrast, not asking implies to the person that you don't care, that he or she is not worth your attention, or that such thoughts are shameful.

10) What if they don't want help?

Persons in psychological distress (depressed, emotionally upset, etc.) often desperately want help, but may believe that to accept help is a sign of weakness or would cause more problems than it solves (see previous question). It sometimes helps to find out why the person is rejecting help; then try to address their concerns. As a bottom line, it is better to be rejected by someone whose life you are trying to save than to try to avoid rejection and lose a life.

SECNAVI NST 6320.24A, 16 February 1999, provides DON policy assigning

responsibility and proscribing procedures to refer, evaluate, treat and administratively manage Sailors and Marines who are directed by their commands for mental health evaluation and/or assessment of risk for potentially dangerous behavior. All DON personnel in supervisory positions should review it.

11) I'm uncomfortable about the topic; can't it just go away?

Talking about suicide has been avoided in western society for centuries. This has only made the problem worse. One goal of the Suicide Prevention video is to emphasize the message that "it's OK to get help." By showing that getting help is a responsible action, we are opening doors for people to problem-solve and find a way to cope with their problems. We have lots of informal and formal ways of providing help within the Navy and Marine Corps community.

12) Don't people who talk about suicide seldom go on to actually do it? Don't people threaten suicide just to get attention?

Most people who think of suicide never act to harm themselves. Obviously, this is a very good thing. But those who talk about suicide are more likely to act on their thoughts. It is also true that a few threaten suicide to "manipulate" others. Since we cannot know who will and who will not attempt suicide, we must respond to all those who communicate their suicidal thoughts by getting them evaluated and treated. Even if a person is trying to gain attention, the fact that he or she might act suicidal or even harm himself or herself in order to get that attention is a sign that the person is in desperate need of our help. People talk about suicide for a wide variety of reasons. Leave the determination of their true motives to professionals who may be able to better understand and help them. Remember--most people who kill themselves mention their thoughts to someone beforehand.

13) Can a suicidal person mask depression with happiness?

We do know that many people suffering from depression can hide their feelings and appear to be happy. The same is true for a person contemplating suicide. But most of the time a depressed person will show signs of depression, and most of the time a suicidal person will give clues as to how desperate he or she is feeling. If we pay

attention, we will do much better at helping those who are suicidal.

14) Aren't people who are suicidal beyond hope? If they really want to die, why should we stop them? Aren't they going to find a way no matter what you try to do to stop them?

The great majority of people seriously thinking about suicide have treatable emotional and psychological problems. They get better with help. We cannot prevent someone from killing himself or herself in every instance. However, it is very important to understand that the suicidal state is usually time-limited. People's moods lift, and situations change. Often, we are buying time until the person is less upset and we have had opportunity to offer some alternative solutions.

15) What is the most common method of suicide?

In the United States, firearms are the most commonly used means of suicide among both males and females.

16) Does suicide run in families?

Several of the risk factors for suicide, including depression and alcoholism, do appear to have a genetic component. In addition, modeling is a powerful influence on children. Coming from a family where a parent suicides both models a way for a vulnerable child to deal with problems and deprives a child of a nurturing and loving parent. Both have life-long influences on that child. For these reasons, a family history of suicide or suicidal behavior is a risk factor for suicide.

17) How does suicide affect family and friends?

Suicide is often extremely traumatic for "survivors," those who care for a loved one or friend. This may seem particularly strange given that suicidal people often feel that no one cares for them. Suicides, as deaths, cause grief, but this is mixed with other feelings: guilt, anger, resentment, remorse, confusion, etc. In addition, the stigma surrounding a suicide can make it extremely difficult for survivors to deal with their grief openly. This makes a loss to suicide even more difficult.

In Navy and Marine Corps, a suicide creates survivors of all hands. As a team committed to our core values and our common goals, we must work together to reduce the traumatic impact suicide has within our commands.

18) Are there seasonal, even monthly, variations in number of suicides?

Suicides occur in every month of the year and in all seasons. In Navy there is no month with more suicides than others. Within the Marine Corps over the past 15 years, January stands out as the month with the most suicides. The reasons for this are not clear. It is probably best to think of suicide as knowing no season. Risk is possible at all times and increases when we are not prepared to observe and note it in others.

Section VI . Six Tips for Effective Facilitation

Effective teaching is an art. The most frequently asked questions regarding facilitating basically break down to questions about how to manage and communicate to a group of learners. The following suggestions are derived from strategies employed by effective teachers:

- If you do not know the answer to a factual question, be honest. You are not expected to be an expert; you are asked to facilitate (help) learning.
- Key points you need to know are in this manual and in the Suicide Prevention video. For some questions, you can meet with the questioner at the end of the session and explore what other resources might be available.
- If your audience displays obvious discomfort with this material, acknowledge that this topic is difficult, that most people are uncomfortable about it, and that together we are trying not to let that discomfort lead to avoidance of the topic. Reinforce the notion that this information can be life-saving!
- On the other hand, respect people's needs to share personal experiences that are stimulated by this material. This may be one of the first times they have had the opportunity to talk about suicide.

- Be prepared. Know your material before you start. Organize your material according to your objectives. Use the overheads provided, as well as materials on local resources that you may collect or create. Have a pre-planned response set up with local medical providers to handle the possibility of being approached by someone with a personal problem.
- Use variety in the way you present material. Use illustrations, questions, and interactive dialogues to keep your teaching interesting and fun (for you, too). Be enthusiastic: vary your gestures and the pitch of your voice; make direct and frequent eye contact.
- Actively listen and respond. Recall and refer to the itemized lists (e.g., risk factors, "when to be concerned") to reinforce these memorable concepts if they are appropriate to interactive discussion and questions.
- Engage your audience by giving them some responsibility for the timing and progress of a session. Adults learn best when they have some investment in the topic and when their interest and contributions are acknowledged positively by a facilitator.

Section VII . Bibliography

SECRETARY OF THE NAVY INSTRUCTION 6320.24A of 16 February 1999

Berman, A. L., and Jobes, D. A. (1997). *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association.

Ellis, T. E., and Newman, C. (1996). *Choosing to live: How to defeat suicide through cognitive therapy*. New Harbinger Publications.

U.S. Office of Personnel Management. (Feb 1998). *Dealing with workplace violence*.

U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC.

Wrobeleski, A. (1989). *Suicide: Why? 85 questions and answers about suicide*. Minneapolis: Afterwords Publishing.