Suicide and the Active Duty U.S. Army

by

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Approved by:

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ABSTRACT

The conflicts waged in Afghanistan and Iraq have manifested a personal conflict within the hearts and minds of the warriors who have fought it. While suicide among military members is not new, the demographics have changed slightly with few in the officer ranks killing themselves. The overall preponderance of suicide victims in the Active Duty Army and Department of Defense (DoD) are white males, 23 years of age, and junior enlisted. Relationship problems are an extremely strong risk factor as it has been historically. In addition, today’s risk factors are previous suicide attempts, substance abuse, and high-risk behavior, all of which are exacerbated by loosened enlistment standards and deferred discipline within the garrison community. The U.S. Army’s response is through Comprehensive Soldier Fitness, Ask, Care, and Escort (ACE) and Resiliency Training both of which are designed to support the soldier in the development of crisis management skills. The U.S. Air Force, which has the model program of suicide prevention of all the DoD branches, espouses many of the recommended best practices on suicide prevention by the RAND Corporation. The Army, which has suffered the apex of suicides, is making marked improvements in the reduction of suicides. The Army Public Health Nurse (APHN) can be an asset and assist in the campaign against suicide through identification of those at risk and follow up care. This overall process to minimize suicides will require utilization of all its assets and the APHN is well trained for the task.

Keywords: Suicide, Army Public Health Nurse, Military
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CHAPTER I
INTRODUCTION

The United States military overall has experienced an increase in suicides since 2001 with the conflicts arising on two theatres of war, Iraq and Afghanistan, as a backdrop. Of the four branches within the armed forces, the U.S. Army has had the greatest suicide rate with 20.2 per 100,000 in 2008 (U.S. Army, 2010). With the increase in rate of Army suicides by approximately 80% from 2004 to 2008, there is a need to utilize the Army’s health care resources with greater efficiency (Bachynski, Canham-Chervak, Black, Dada, Millikan, & Jones, 2012).

The overall goal of this paper is to examine suicide within the active army component in comparison to other Department of Defense (DoD) entities. In addition, current interventions to prevent suicide and its impact such as the Army Suicide Prevention Program (ASPP) and other supportive indices are described. The current roles of the Army Public Health Nurse (APHN) according to Department of the Army Pamphlet 40-11 Preventive Medicine are examined. Lastly, possibilities to enhance those roles and establish new methods to assist with the identification and support of those at risk for suicide as well as follow up care once initiated are discussed.

The APHN has the public health skills needed to address the many facets of suicide prevention. With the current suicide crisis within the U.S. Army, all opportunities to assist those at risk must be seized. The APHN, with his/her public health skill set, is an underutilized asset in this endeavor.
What is Self-Directed Violence?

There are three categories that capture violence or the desire to commit violence upon oneself: suicide, suicide attempt, and suicide ideation. The Centers for Disease Control and Prevention (CDC, 2011a) defines these categories as follows:

**Suicide:** death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

**Suicide Attempt:** as a non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. The CDC further notes a suicide attempt may or may not result in injury.

**Suicide Ideation:** thinking about, considering, or planning to commit suicide.

Backdrop

Annually, there are almost a million deaths worldwide from suicide (World Health Organization, 2012). Suicide occurs more frequently than homicides or war-related deaths (Domenici, n.d.). In the U.S., suicide is the 10th leading cause of death with over 36,035 deaths reported in 2008 with a suicide death frequency every 15 minutes (Crosby, Han, Ortega, Parks, & Gfroerer, 2011).

If the incidence of suicide is high, the attempts, thoughts, and contemplations are astronomical. According to the CDC (2009), the suicide rate for adults age 18 and older was 15.2 per 100,000; the hospitalization rate was 86.0 per 100,000; and the emergency department visit rate was 140.6 per 100,000. According to Crosby et al. (2011), 8.3 million people (4%) of the adult population have admitted to suicidal
thoughts, 2.2 million people (1%) have made plans to commit suicide, and 1 million people (0.5%) have made suicide attempts.

**Civilian Demographics**

According to the CDC (2009), suicide within the civilian sector has been declining with exception of the 25-64 year old age group, based on national suicide statistics from 2002-2006 (Figure 1.1). By race, the highest rates of suicide are for American Indian/Alaskan Natives, and Non-Hispanic whites (Figure 1.2), and by gender, males are significantly higher victims to suicide. Suicide death by firearms is the leading method for males, while females 10-24 years of age die mostly by suffocation; those 25-64 years of age die mostly from poisoning, and those 65 years of age utilize firearms as a primary mechanism (Figure 1.3).
From 1991 to 2003, suicide rates were consistently higher among those 65 years and older compared to the younger age groups. The suicide rates in this age group declined from 19.70 suicides per 100,000 in 1991 to 14.22 suicides per 100,000 in 2006. The suicide rates also declined among those 10 to 24 years from 9.24 suicides per 100,000 in 1991 to 7.01 suicides per 100,000 in 2006. Suicide rates among those 25-64 years declined from 15.07 suicides per 100,000 in 1991 to 13.43 suicides per 100,000 in 2000. From 2000 to 2006, the suicide rates among the 25-64 year age group increased to surpass the rate of those 65 years and older in 2004 and again in 2006.

Footnote: *All rates are age specific. Rates based on less than 20 deaths are statistically unreliable.

(Centers for Disease Control and Prevention, 2009)
During 2002-2006, the highest suicide rates were among American Indian/Alaskan Native males with 26.18 suicides per 100,000 and Non-Hispanic White males with 24.69 suicides per 100,000. Of all female race/ethnicity groups, the American Indian/Alaskan Natives and Non-Hispanic Whites had the highest rates with 6.70 and 6.15 suicides per 100,000, respectively. The Asian/Pacific Islanders had the lowest suicide rates among males while the Non-Hispanic Blacks had the lowest suicide rate among females.

Footnote: *All rates are age-adjusted to the standard 2000 population. Rates based on less than 20 deaths are not shown, as they are statistically unreliable. ** AI/AK Native: American Indian/Alaskan Native, PI: Pacific Islander

(Centers for Disease Control and Prevention, 2009)
During 2002-2006, the greatest percentage of suicides among males in each age group, 10-24 years, 25-64 years, and 65 years and older occurred by firearms (51.9%, 53.3%, and 79.2%, respectively). The greatest percentage of suicides among female’s ages 10-24 years occurred by suffocation (43.0%). The greatest percentage of suicides among females ages 25-64 years occurred by poisoning (42.5%) and firearms (35.2%) among females 65 years and older.

(Centers for Disease Control and Prevention, 2009)
CHAPTER II
LITERATURE REVIEW

History and Trends of Suicide Within the Military Population

Unfortunately, suicide has been a situation plaguing the military forces. According to Rothberg & Jones (1987), historically soldiers were more likely to commit suicide compared to their civilian counterparts. Data from 1870-1884 revealed soldiers committed suicide at a rate of 680 per 1,000,000 soldiers compared to 80 per 1,000,000 civilians belonging to the same age group. A relevant point was identified that the suicide rate decreases in response to a “popular war” that unites the nation. Suicide rates in male soldiers from 1910-1982 showed a marked decrease in suicide rates and were noted by two distinct dips during World Wars I and II.

Rothberg and Jones also reported for the period 1975 to 1982 there were 831 suicides at a rate of 13.5 cases per 100,000 soldiers. The male suicide rate was 12.7 cases per 100,000 and the female’s rate was 9.9 per 100,000. The average age of suicide for enlisted males was 25 and for enlisted females was 23. Historically, officers have committed suicide at a rate greater than their enlisted counterparts equaling a rate of 14.7 per 100,000 for officers compared to 7.6 per 100,000 for enlisted personnel. When compared to officers, the average age of suicide was 34 for male officers and 29 for female officers. White males committed suicide twice as often as black males at a rate ratio of 2.1 to 1.0. The rate of female suicide compared by race is striking. White females committed suicide at a rate ratio of 4.9 to 1.0 compared to black females.
During this period, Rothberg and Jones (1987) reported several risk factors for suicide with relationship issues the leading cause (Table 2.1). Divorced and separated soldiers had a risk rate that was seven times that of married soldiers. Stressors noted for this group of soldiers who committed suicide included difficulties with love interests as a leading cause at 68.6%, which included divorce or breakup, altercation, inability to get along, and/or violence as important factors. Other causes of suicides included difficulties at work (Army) at 36.2% and financial problems at 14% of stress sources. Legal troubles other than absence without leave (AWOL) were listed as 14% and AWOL/desertion accounted for 6% of stressors leading up to suicide. Finally, medical/health problems as a stressor were cited in 7.4% of the suicides. Methods used to inflict self-harm were primarily firearms and suffocation with firearms as the primary mechanism of suicide for 60% of men compared to 45.2% for women.

**Suicide After September 11, 2001**

On September 11, 2001, the nation was assaulted by the phenomenon of terrorism in the form of aircraft hijacking and using the aircraft itself as a weapon of destruction. America and those in alliance demanded justice and began the quest to obtain it. This resulted in armed conflict in two theaters, Afghanistan and Iraq, which was unique to modern warfare due to the asymmetric quality of combat engagement. This has resulted in casualty trends unique to this almost decade long conflict that will endure indefinitely. According to Ramchand, Acosta, Burns, Jajcox, & Pernin (2011), since 2001, the beginning of armed conflict in Afghanistan and Iraq, there has been an increase in suicide of U.S. service members resulting in a 50% increase in the total
TABLE 2.1
RISK FACTORS FOR SUICIDE AMONG MILITARY PERSONNEL

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<thead>
<tr>
<th>RISK FACTORS</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>Divorced/Separated</td>
<td>68.6</td>
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<tr>
<td>Work Related Difficulties</td>
<td>36.2</td>
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<tr>
<td>Financial Problems</td>
<td>14.0</td>
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<tr>
<td>Legal Troubles</td>
<td>14.0</td>
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<tr>
<td>AWOL/Desertion</td>
<td>6.0</td>
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<tr>
<td>Medical/Health Problems</td>
<td>7.4</td>
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(Rothberg & Jones, 1987)
military suicide rate with an almost doubling of the U.S. Army rate from 2001 to 2008. While the general population U. S. adjusted rate has remained constant, the rate reported by the DoD has increased from 10.3 per 100,000 in 2001 to 15.8 per 100,000 by 2008. The numbers of reported suicides by military branch are shown in Table 2.2 with suicides reported by the Army more than two times that of all other branches combined.

Department of Defense Suicide Statistics

Since October 2001, more than 2.16 million troops have been deployed (Cesur, Sabia, & Tekin, 2011). As of February 13, 2012, 5,007 military personnel have been killed and 47,545 have been wounded in action (DoD, n.d.). From January 2001 to September 27, 2011, 2,293 active duty personnel have committed suicide (Wong, 2011), and in 2010 alone, 295 service members died by their own hand (Kinn, Luxton, Reger, Gahm, Skopp, & Bush, 2011). According to DoD Suicide Event Report Findings (Kinn et al., 2011), post 9/11, active duty components were at a 70% greater risk than reservists and guardsmen who were activated and deployed. Of all completed suicides reported for the entire DoD, 91% were on active duty. The breakdown of service members successful for suicide were 95.4% male, 79.7% Caucasian, 47.5% under the age of 25, and 54.6% junior enlisted (E1-E4).

Methods

For completed suicides, firearms were the primary methods used at 62% with 48% being non-military issued firearms. Firearms were in the home or immediate
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(Kinn et al., 2011)
environment in 52% of suicide successes but only 11.6% of the suicide attempts. Hanging as a suicide method followed at a distant second at 24.6%. For suicide attempts the most common method used was drug overdose at 57.5% (Kinn et al., 2011).

For those who attempted suicide and survived, substance abuse was a common association. Both drug and alcohol use was associated with 21.7% of attempts. Drugs were involved in 62% of suicide attempts and alcohol was involved in 33% of attempts. Of the service members who attempted suicide and died, 25.6% had a known history of substance abuse. For unsuccessful suicide attempts, 23.4% had a known history of substance abuse. Psychotropic medication was noted in 46.4% of suicide attempts and 24.2% of completed suicides (Kinn et al.).

**Mental Health/Social Issues**

Known mental health disorders among the DoD population who completed suicide and attempted suicide reveal opposing data. For successful suicides, 43.4% of personnel had a diagnosed mental health disorder. For suicide attempts, 63.7% had at least one mental health diagnosis. Outpatient treatment for a mental health disorder was more common for suicide attempts at 44.2% compared to 24.4% of those who completed suicides (Kinn et al.).

Of those service members with known mental health diagnoses and successful suicides, 17% had mood disorders with major depressive disorder being the most common at 7.1%. Anxiety disorders were associated with 15% of the suicides with post-traumatic stress disorder (PTSD) being the most common at 5%. Approximately
25% of service members had a substance abuse diagnosis. For those who attempted suicide, mood disorders were noted for 38.9% with a major depressive disorder being most common at 17.7%. Anxiety disorders were associated with 26.1% of attempters and 8.2% had PTSD (Kinn et al., 2011).

Also, according to Kinn et al., prior to September 11, relationship issues were the basis for suicidal behavior in many cases. Unfortunately, that trend holds constant. Relationship failures were noted in about half of all suicide completions and attempts with 29.9% in the month prior to the suicide event for those completing a suicide and 32.8% the month before for the attempted suicides. For those divorced, the suicide rate was 55% higher than for those who were married.

Relationship violence was common with those who completed suicide as well as those who made attempts. The difference was the recipient of abuse. Those who completed suicides were more likely to perpetrate an act of abuse while those who attempted suicide were more likely to be victimized.

Other factors stimulated suicidal intentions as service members dealt with the same economy and other domestic factors as their civilian counterparts. Job loss, which is assumed to be separation from military service involuntarily, instability, and demotions occurred with 19% of suicide completions and 32% of suicide attempts. The most frequent legal matter known was Article 15 proceedings which is a non-judicial form of punishment for 21% of suicides and 17% of suicide attempts (Kinn et al.).

Communicating the likelihood of suicide to others was not a common event for the DoD population. Only 34% of those who completed suicide and 22% of those who attempted suicide notified another person of the intent. Most often the communication
was verbal for both suicides (21%) and attempts (17%). Modern means of communication are now used as well to convey suicidal intentions. Texting has been a recent method of communicating suicide potential and occurred for 5% of suicide completions and 1% of suicide attempts (Kinn et al., 2011)

**Deployment**

The role of deployment and suicide is not clearly understood; however, deployment is associated with those risk factors that contribute to suicide (Holloway & Branlund, 2011). In addition, the authors noted that deployment-related factors such as length and number of deployments, exposures to injury, illness or traumatic events, and personal variables were probably associated with the increased risk for suicide. However, a DoD report noted multiple deployments were not an overwhelming factor for suicides or suicide attempts. For those who committed suicide, 46% had deployed to Operation Enduring Freedom (OEF) Afghanistan, Operation Iraqi Freedom (OIF), or Operation New Dawn (OND) Iraq. Only 6% had multiple deployments to those theatres (Kinn et al.). Holloway and Branlund noted for military who committed suicide out of theater about 33% had at least one deployment and 14% had two or more. They also mention, for those military personnel that committed suicide and had never deployed, it is unknown how many were pending a deployment.

In relation to deployment and suicide attempts, for those who attempted suicide 41% deployed to OEF, OIF, or OND and 5% had more than one deployment. Also, direct combat experience was reported in 11% of suicides and 14% of suicide attempters. In addition, suicide completions and attempts were rare during
deployments to OEF, OIF, or OND for 11% of suicides and 5% of attempts. Only 6% of suicides occurred at an OEF location and 4% at an OIF or OND sites (Kinn et al., 2011)

**Economic Impact**

As a nation, the costs of the impact of war are shared. Financially, suicide-related deaths and injuries result in more than $25 billion in direct and indirect costs (Martin, Ghahramanlou-Holloway, Lou, & Tucciaroni, 2009). Cesur et al. (2011) studied the two-year estimated costs related to PTSD in relation to the global war on terror (GWOT) and found the costs to be between $1.5 and $2.7 billion. The per person price tag of the two-year estimate for the health care costs of PTSD was reported to be between $5,904 and $10,298; however, costs do not take into consideration the effect on lost productivity within the labor market, the emotional and personal tolls on marriage, and other socioeconomic outcomes. The costs are only the immediate consideration health care costs.

**Suicide in the U.S. Army**

Research by the U.S. Army (2010) finds the “typical” suicide victim within the active duty Army is a 23-year-old Caucasian, junior-enlisted male. The U.S. Army, which is comprised of active, reserve, and National Guard components, has experienced an almost doubling of its suicide rate over the past decade. From 2003 to 2009 the rate increased from 11.4 to 21.7 per 100,000. This jump in soldier suicides from 79 to 162 per year over the 7-year period realized more troops being killed by their own hand than by enemy forces, in some years.
It is hypothesized that stress may be greater in the Army population due to high dependence in the military environment of friends and coworkers for social support (Black, Gallaway, & Bell, 2011). Loss of family or friendship structure appears to be devastating to a population revered for its hardiness. In addition, increased availability of firearms within the military population enables capability for suicide violence (Black et al.).

According to Black et al., the similarities involving the increase in suicide risk for gender and race were found to be similar compared to the age-adjusted civilian population. While mood disorders, relationship disturbance, and substance abuse are common companions to suicide completion, one of the strongest indicators is a prior suicide attempt. Within the 18-24 year old age group, military and civilian stress is typical and associated with steep changes of life stress. The same is the case of mental health disorders being a suicide risk factor in and among the civilian population. The Active Army soldier has, in addition to the normal stressors of his or her age range, a unique set of stressors. However, the preparation mentally and financially may not be present. In addition, stress loads, for some, may increase more rapidly with minimal time for coping and adjustment. There may be stress due to guilt, anger, or humiliation that could accompany the stress of relationship issues, legal matters, or poor work performance.

**Demographics**

The demographics of the active duty U.S. Army in 2009 were 86.6% male and 96.9% of the active Army suicides were male (U.S. Army, 2010). Males are four times
more likely to die by suicide compared to females (Martin et al., 2009). The Army population is 62.7% Caucasian and 76.7% of the suicide deaths were Caucasian (U.S. Army, 2010). The modal age for suicide is 23 for the active Army (U.S. Army). For the span of 2001-2009, the largest group of active duty suicides fell within the 18 to 24 year old range at 45% (Black et al., 2011). When examining rank and suicide from 2001 to 2009, the highest proportion of suicides involved junior enlisted ranks E-1 to E-4 at 57%, followed by senior enlisted soldiers ranked E-5 to E-9 at 33%. Army officer suicides in the junior grades O-1 to O-3/W1-W3 were 5.8% and in the field grades, O-4 to O-9/ W4-W5, was 3.6% (Black et al.).

There are numerous transitions and unstable periods in a soldier’s career. These periods, sometimes overlapping, can be quite stressful and create areas of personal isolation for the soldier. Black et al. state the majority of the suicides (79%) displayed evidence of personal stressors such as relationship problems, military related stress, and physical health issues (Table 2.3). Approximately 19% of suicides were related to deployment and one-third had evidence of contributing factors from childhood or prior to entry into the Army. Ten percent of the suicides studied had a history of self-injury and 19% involved issues with alcohol with 8% involving drugs. Previous suicide attempts are a very strong risk factor of suicide.

For those individuals who have completed suicide, 30% to 40% have attempted suicide in the past (Allen, Cross, & Swanner, 2005). Allen et al. also noted there was a successful suicide for every 18 attempts. The Mental Health America website reported the ratio of attempted suicides to completed suicides is close to 10 to 1, and that the risk of completed suicide is more than 100 times greater than someone without a previous
**TABLE 2.3**

**THE TOP SEVEN SUICIDE RISK FACTORS FOR MILITARY PERSONNEL**

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<td>Unexplained mood changes, depression</td>
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<tr>
<td>3.</td>
<td>Feelings of disgrace/isolation, hopelessness</td>
</tr>
<tr>
<td>4.</td>
<td>Financial, legal, or job performance problems</td>
</tr>
<tr>
<td>5.</td>
<td>Alcohol use/abuse</td>
</tr>
<tr>
<td>6.</td>
<td>Medical or administrative discharge</td>
</tr>
<tr>
<td>7.</td>
<td>Previous suicide attempts</td>
</tr>
</tbody>
</table>

(Martin et al., 2009)
attempt within the first year after an attempt (America, 2012). Lastly, 31% of the suicides had a history of legal problems.

According to Black et al. (2011) between 2004 and 2009, 90% of the 557 Army suicides reported were associated with some level of stress load, and the average number of stressors increased from less than two to greater than eight. Over 60% of the suicide completions had three or more stressors simultaneously (Table 2.4).

**Individual Risk Factors and Stressors**

Suicide is the manifestation of events that began in childhood (Butcher, Mineka, & Hooley, 2007). For some within the population, there are events and possibly genetic factors that occur that predispose them to suicide as an adult. Family instability and abuse as child may create a template for psychopathology and suicidal behavior. Inheritable qualities that may predispose to family instability, abuse, and suicidal behavior are psychiatric disorder and impulsive aggression, and if both are manifested together, the risk for suicidal behavior is greater (Brent & Mann, 2005).

Other than mental health conditions, circumstances for suicide noted most often were a crisis of some kind during the preceding or impending two weeks (27.9%) or intimate partner problems (30.9%) (Karch, Logan, & Patel, 2011). Many suicides occur without indication of exacerbating causes. However, in 41.2% of cases, when the motivation for suicide was expressed, emotional relief was the number one cause at 15.2% (U.S. Army, 2010). Depression and hopelessness together are second at 14.2% and avoidance or escape was noted in 7.5% of suicide cases (U.S. Army). In another
<table>
<thead>
<tr>
<th>No. of Stressors</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>one or two stressors</td>
<td>25.8</td>
</tr>
<tr>
<td>three or four</td>
<td>23.9</td>
</tr>
<tr>
<td>five to seven</td>
<td>24.1</td>
</tr>
<tr>
<td>eight or greater</td>
<td>16.0</td>
</tr>
</tbody>
</table>

(Black et al., 2011)
study of active duty suicides, 82% of these suicides had at least one stressor (U.S. Army, 2010).

Additional factors such as feelings of isolation, hopelessness, helplessness, worthlessness, and guilt can have an impact on the soldier. A study from the Johns Hopkins University (Sudikoff, 2010) found that among college students the greatest factor of suicide prediction was the feeling of being unloved or detached from friends or family, that is, a feeling of isolation. Support from family once a soldier is assigned to a base or Forward Observation Base (FOB) once deployed can dwindle. Making friends can be challenging for some personalities and loneliness can ensue despite being surrounded by other people. To make matters worse, dependent upon location, the ability to travel may be limited for an indefinite period. For those whose maturity is yet developing, this could be overwhelming.

Hopelessness may be a long-term predictor for suicide (Butcher et al., 2007). The Army defines hopelessness as a strong sense of futility, due to the belief that the future holds no escape from current negative circumstances (Department of the Army, 2010b). The person may feel no resources exist to alleviate the situation bringing about the despair.

The military in essence encourages a dependence upon one another and the legality of structured rank. For some, this may be overwhelming when a superior rank gives a subordinate a legal order that goes against the persons will and desires. Based upon the feeling of futility in effort, helplessness occurs when the soldier can feel powerless (Department of the Army, 2010b). The individual does not feel empowered to overcome the overwhelming stressor.
When the soldier feels absence of value by others, worthlessness ensues (Department of the Army, 2010b). The sum total of many negative encounters where effort is expended to fit in and be successful without appreciation or success may yield a feeling of "not good enough" or like a failure. Feeling devalued by others or self-imposed may cause feelings that 'my family or the unit may be better off without me'.

A strong sense of shame when the soldier feels they are wrong is guilt (Department of the Army, 2010b). This could be self-imposed or the soldier may be made to feel at blame by others. The feeling of guilt may elicit the desire to self-punish or to make things right with the ultimate sacrifice.

Examining sources of stress, Bray, Pemberton, Lane, Hourani, Mattiko, & Babeu (2010) noted over a 12 month period for the years 2002, 2005 and 2008, the top 4 stressors were found to be conflicts between military and family responsibilities, being deployed, increases in work load, and being away from family. Also, a noted increase during that period from 5.5% to 9.5% was stress associated with a permanent change of station. In addition, in 2008, stress from work and home were assessed independently. Of those surveyed, 27.1% indicated a lot of stress at work and 29.3% indicated some work stress. Stress from home was noted with 17.6% indicating a lot of stress while 20.6% indicating some home-related stress.

**Family, Career, Financial, and Physical Health Stressors**

Marriage was not found to be a protective factor for the Army population, which is often the case for the civilian sector (Black et al., 2011). Rates of suicide attempts are three or four times higher in those divorced or separated (Butcher et al., 2007). The
DoD noted the suicide rate for divorced service members was 55% higher than for married members (Kinn et al., 2011).

Intimate partner problems also were cited as a precipitating factor in a higher percentage of male suicides than female suicides (32.3% and 25.9%, respectively). Although occurring in only a limited percentage of cases, being a perpetrator of interpersonal violence in the month before a suicide death was more common among male suicide decedents (5.2%) than being a victim of such violence (0.3%), whereas, the proportions were more similar for females (1.3% and 0.8%, respectively) (Karch et al., 2011).

Suicides generally increase after a drawdown. This has occurred 3 times in the past 20 years (Wong, 2011). For those with the intention of being career soldiers, involuntary separation may create stress. Job and financial problems were each noted in 13.4% of deaths (Karch et al., 2011). The Health Promotions Risk Reduction and Suicide Prevention report (U.S. Army, 2010) addressed the increase in economic stress associated with transitions within the military. Movement to the next duty station and to and from a deployment may create more stress, especially if the soldier or family is already financially stressed. During the current economy, if a soldier needs to sell a home this could be very tenuous. Also, personal variables such as emergency leave and loss of equipment or property may create or catch a soldier or family at a financially vulnerable time.

In 2009, 23.2% of suicides of active duty soldiers could be attributed, at least partially, to physical health issues (U.S. Army, 2010). Approximately the same percentage of male (21.9%) and female (24.9%) suicide decedents experienced
physical health problems in the period before their deaths. Physical health problems also were noted in 22.6% of cases with vague suicide risk factors (U.S. Army, 2010).

**Psychological Health Factors**

Karch et al. (2011) noted in their study that precipitating circumstances were known for approximately 90% of suicide deaths. Overall, mental health problems were the most commonly noted circumstance for suicide decedents with 41.6% described as experiencing a depressed mood at the time of death. Approximately 45.4% of decedents were described as having a diagnosed mental health problem, although only 32.9% were receiving treatment. Of those with a diagnosed mental disorder, 74.6% were diagnosed with depression/dysthymia, 14.9% with bipolar disorder, and 9.3% with an anxiety disorder. Among those with a diagnosed mental health problem, females were more likely than males to have been diagnosed with bipolar or anxiety disorders, while males more often than females were diagnosed with PTSD, attention deficit disorder/attention deficit, and hyperactivity disorder (ADD/ADHD).

Allen et al. (2005) found approximately 90% of those who committed suicide suffered from at least one diagnosed psychiatric condition. Research by Black et al. (2011) found within the military population, 46% of soldiers who committed suicide had at least one mental health diagnosis. Also, 31% of soldiers who had more than one mental health diagnosis committed suicide.

The relative risk rate for suicide of soldiers with a history of a mental health diagnosis was 4.7 times higher than for soldiers without any history of a mental health diagnosis. In addition, for soldiers with a history of inpatient care, the relative risk rate
was 19.8, and for outpatient soldiers the suicide rate was 4.7 when compared to soldiers with no history of mental health diagnosis (Black et al., 2011).

Of all mental health disorders, depression is most common. According to the American Association of Suicidology (AAS) (2009), the lifetime risk of depression ranges from 6% to 25%. The AAS also cites that the National Institute of Mental Health (NIMH) reports 18.8 million or 9.5% of adult Americans suffer from depression in any given year. A mood disorder, primarily a major depressive disorder, is antecedent in 30% to 90% of all suicide cases with a known mental health disorder (Martin et al., 2009). Mood disorders affected 20% of successful soldier suicides. In addition, 25% of suicides were associated with an adjustment disorder diagnosis (Black et al., 2011).

The AAS (2009) also noticed the lifetime risk of suicide for those with untreated depressive disorder is nearly 20%, but for those with treated depression it is less than 1%. When depression is not treated, substance abuse, recurrent episodes of depression, and suicide can occur. Treatment of depression is effective in preventing suicide 60% to 80% of the time. The risk of suicide for those with major depression is about 20 times higher than for the general public. Major depression is the mental health issue most commonly associated with suicide. Two-thirds of those who commit suicide are depressed at the time of death. For individuals diagnosed with depression during their life, 7 of every 100 men and 1 of every 100 women will commit suicide.

The Army as well as the military as a whole is facing a monumental problem of healing its mentally wounded. PTSD has affected almost 500,000 military personnel of which one-half are U.S. Army troops. In 2010, 11,000 cases of PTSD and 15,000 concussions were diagnosed (Zoroya, 2012).
According to Cesur et al. (2011), soldiers serving in combat zones are at greater risk for PTSD, and are more likely to receive psychological or emotional counseling than those on active duty serving outside the United States in non-combat zones. It is estimated that PTSD rates range from 4% to 45% for all service members serving in Iraq or Afghanistan. In another study, 13% of Army personnel met the screening criteria for PTSD, and with 71% of the Army having served at least one deployment, the potential for PTSD diagnosis may be increased. The number of PTSD cases increased from 2,391 in 2004 to 10,137 in 2008, and the percentage of those committing suicide diagnosed with PTSD increased from 4.6% in 2005 to 14.1% in 2009 (U.S. Army, 2010).

**Substance Abuse**

Martin et al. (2009) report that the second most often co-occurring mental health disorder in 26% to 55% of suicide cases is a substance-related disorder. Comorbidity of mental health and substance disorders preceded deaths in 38% suicide cases versus only 6% in non-suicide deaths. The authors noticed in drug-related suicide attempts of individuals 18 years of age and older, 33.2% had utilized alcohol and 28.4% had utilized illegal drugs such as marijuana and cocaine. However, 58.9% of those who attempted suicide used psychotropic medications and 36% used pain medications, opioids, NSAIDs, and acetaminophen. It is unknown if these medications were prescriptive.

According to Allen et al. (2005), alcohol dependence or heavy alcohol consumption was found to be a significant risk factor associated with suicide. Of those committing suicide in America, 20% are by alcoholics. Eventually, 3% to 7% of alcoholics commit suicide and the lifetime risk of suicide for alcoholics is 60 to 120 times
that of non-alcoholics. In a study of health maintenance organization participants, enrollees who averaged 6 drinks per day were found to be 5.4 times as likely to commit suicide compared to the reference group, which abstained or drank alcohol at a low level. For alcoholics, the risk of suicide is dependent upon the severity and duration of alcoholism, social isolation, and concurrent depression. The effect of alcoholism and suicide differ by age grouping. Although age ranges were not specified, for younger alcoholics, recent loss and unemployment are associated with suicide and for older alcoholics, suicide is related to medical fitness and depression. However, for recovering alcoholics with alcohol abstinence, the risk decreases.

Acute alcohol intoxication is a significant risk factor for suicide as well, and Allen et al. (2005) identify four reasons for the elevated risk: heavy alcohol consumption and withdrawal increases stress levels, alcohol raises aggression, also it lowers inhibition, and lastly heavy alcohol consumption decreases problem solving abilities.

Two-thirds of individuals who commit suicide have seen a physician within the month prior to their demise. Screening for depression and alcoholism are not recommended due to the low specificity and sensitivity with suicide screening tools. Close coordination between the health care provider and command is thus highly recommended (Allen et al.).

The Army has the highest rate of acute alcohol diagnosis and substance abuse clinic treatment encounters within the DoD community. Annually, for 2006-2008, there were 22.7 acute alcohol ingestion cases per 1,000 visits and 43.2 substance abuse clinic encounters per 1,000 visits. For active duty personnel, alcohol was involved in 19.8% of suicide cases and drugs in 9.8% of suicide cases. This is especially true of
those soldiers who have deployed. Drugs and alcohol were involved in 30% of the Army’s suicide deaths from 2003 to 2009 and more than 45% of the non-fatal suicide behavior from 2005 to 2009 (U.S. Army, 2010).

Illicit drug use in the military has declined from 28% in 1980 at to 3% in 2002 (Bray et al., 2010); however, prescription drug misuse has increased from 4% in 2005 to 11% in 2008. There has been an increase in prescribed antidepressants within 90 days of deploying or during a deployment, from 1.1% in 2005 to 5% in 2008. About one-third of Army personnel use prescription drugs of which 14% are opiates. Oxycodone and percocet have become the second and third most commonly used pain medication within the Army (U.S. Army, 2010).

Military Risk Factors

Deployments

As opposed to DoD personnel in general, U.S. Army soldiers were found to have a greater risk for suicide with two or greater deployments (Chedekel, 2012). According to Cesur et al. (2011), the psychological costs of combat are greatest for those soldiers exposed to violent combat events such as frequent enemy firefights. At high risk for suicide ideation, depression, and PTSD are soldiers exposed to killing or who have witnessed killing or wounding. PTSD has a stronger association with deployments greater than four months (Holloway & Branlund, 2011). Also, at risk are soldiers who themselves are injured in combat. What is revealed in the research is that it is not the deployment itself but the characteristics of the deployment. Thus, Cesur et al. (2011)
suggest deployment schedules that consider soldiers experiences as opposed to cumulative deployment length.

**Breakdown in Discipline**

Due to the GWOT, the Army has deemphasized garrison, a military base leadership and management and replaced it with combat technical and tactical training (U.S. Army, 2010). This necessary transition of focus has been advantageous to soldiers troubled with discipline issues. Thus, there has been an increase in crime, both civilian and martial.

In response to the increase in suicides, the Vice Chief of Staff of the Army commissioned a study to examine the root cause of the suicide increase which revealed an increase in high-risk behavior, variable quality of the health promotions and suicide prevention programs, and decreased leadership (U.S. Army). In addition, the opportunity for high-risk behavior to thrive was prime. The overall primary reason being garrison leadership was limited (U.S. Army).

Many commanders and subordinate leaders are not getting the experience of managing soldiers in garrison (U.S. Army). This created a void, in some cases, of good order and discipline in the garrison setting. Enforcement of rules and regulations are crucial to good order and discipline and essential with those attracted to risk.

The steep increase in crime against vulnerable populations is alarming. According to Zoroya (2012), within the U.S. Army population, sex crimes have increased by 32% since 2006 and domestic abuse has increased by 50% from 2008 to
2011 (4,827 cases to 7,228 cases). Also, in the same period, child abuse has climbed 62% from 3,172 cases to 5,149 cases.

There are other issues of discipline slack as well including soldiers who have violated policy and remained on active duty. Approximately 1,054 soldiers have committed two or more felonies. There are more than 1,318 soldiers who have failed multiple (greater than two) drug tests. These aforementioned soldiers remain on active duty due to system errors that missed these transgressions (U.S. Army, 2010).
CHAPTER III

U.S. ARMY’S RESPONSE

The U.S. Army Response to the suicide epidemic has been an aggressive campaign primarily utilizing the media directed towards those most at risk. The "emotional well being of the force" is the targeted variable. The Army uses two primary approaches: "soldiers take care of soldiers" and the holistic approach to soldier care.

All services under the DoD provide a suicide prevention program, of which the Air Force has demonstrated effectiveness and is thus highly regarded. The U.S. Army is now starting to generate data that the Army is healing. It was reported on the weekend edition, January 20-22, 2012 of the USA Today, Zoroya (2012) that Army suicide rates had declined for the first time in four years. For Active Duty, Reserve Component, and National Guard soldiers combined, suicides fell 9%. The decrease from 2010 of 304 deaths to 278 in 2011 is hailed as a success. However, the Army’s suicide rate is 24 per 100,000 soldiers, which is still higher than the age-adjusted civilian rate of 19 per 100,000 persons. Even worse, for soldiers who have been deployed to either the Iraq or Afghanistan theatres, the rate is 38 per 100,000 soldiers. The recent decrease in numbers of suicide deaths is attributed to efforts to identify soldiers engaged in high-risk behaviors and activities. Hospitalizing soldiers who have spoken of suicide has increased, indicating improved identification of those at risk.
Prevention

The goal of suicide prevention is to minimize risk factors and enhance resilience (CDC, 2011b). The stages of prevention primarily focus on primary or preventive strategies. For those who identify themselves as suicidal, the secondary stage helps to aid those soldiers in their moments of crises to reverse the mind state and decrease the likelihood of a suicide attempt. Lastly, in the event of a suicide attempt or an actual suicide completion, tertiary prevention interventions are appropriate to minimize the chances of a repeat attempt or other soldiers to emulate suicidal behavior.

Methods include increasing protective factors and reducing risk factors and their impacts. In addition, strategies need to be implemented at each strata of the socio-ecological platforms of individual, interpersonal, community, and population (CDC, 2011b). A comprehensive multi-focal approach is indicated to address suicide in the Active duty Army population.

DoD Suicide Prevention and Risk Reduction Committee

The DoD sponsors the Army, Navy, Air Force and Marines suicide prevention programs. They come together in the form of the DoD Suicide Prevention and Risk Reduction Committee (SPRRC). The SPRRC is comprised of the suicide prevention program representatives from each service who primarily share information and develop products.
Branch Programs

The Air Force suicide prevention program (AFSPP), which noted a 33% risk reduction in suicide, works by changing the culture of the Air Force, from top to bottom of the rank structure and how the Air Force itself views suicide (Ramchand et al., 2011). This program addresses each aspect of the socio-ecological model through education of the individual as well as his or her responsibility to fellow airmen. In addition, the AFSPP has established policies and procedures for monitoring and protection of the service member’s identity (Ramchand et al.).

The Navy, which has sailors on land and sea, rely on early intervention and placing behavioral health assets in places the sailor can easily access. The Navy Stress Continuum identifies varying stages of stress with a color to identify assistance needs. The continuum begins with ready (green) indicating wellness and places the responsibility of prevention at leadership level. Once there is a stress response identified as mild and temporary, this stage is called reacting (yellow) followed by a more severe and persistent stage, injured (orange). Both the yellow and orange zones place the responsibility of care upon the individual, shipmate, and/or the family member to assist or provide care. Those with persistent and disabling mental health needs, the most severe designator termed ill (red), are to be referred to a mental health caregiver (Figure 3.1). In addition to the Navy Stress Continuum, there is an emphasis on suicide prevention campaigns and education for all of its personnel (Ramchand et al.).
Figure 3.1
THE NAVY STRESS CONTINUUM

(Navy Medicine, n.d.)
The United States Marine Corps (USMC) approach to suicide prevention is to identify and refer marines who appear to be at risk for suicide. The training is delivered at key points such as upon enlistment, pre- and post-deployment, and annually. The gatekeeper approach attempts to identify marines with substance abuse, family, and other problems indicative of high stress. This suicide prevention program also is supported by a campaign against suicide throughout the corps (Ramchand et al.).

**Army Suicide Prevention Program**

The purpose of the Army Suicide Prevention Program (ASPP) is to reduce the risk of suicide through policies, programs, and training that mitigate suicidal behavior in addition to tracking data (Department of the Army, 2010b), and is established by Army Regulation 600-63 and guided by Department of the Army Pamphlet 600-24 (Department of the Army, 2009). The ASPP functions through prevention, intervention, and postvention. The Army realizes that suicide may occur even with the best leadership and programs in place. The overreaching goal of the ASPP program is to lower the probability that an individual will engage in self-destructive behavior. This requires an intimate relationship of commanders with their subordinates and the understanding of their lives and concerns.

Within the structure of this program, prevention is key and involves the usage of “Gatekeepers,” which is defined as an individual who is assigned the duty and responsibility to provide counseling to soldiers and others in need. The key is to prevent normal life stressors from becoming life crises. This is done through early screening and establishing a baseline mental-health level with targeted programs and
therapy to assist the soldier before a serious problem manifests itself. The Unit leaders are the Gatekeepers and are expected to know their soldiers well enough to understand their approximate stress load capability. In addition, efforts to prevent an individual from committing suicide such as listening, empathizing, and escorting an individual to professional assistance during a crisis are very important. Alterations of the environment that may have brought about the current crisis, treatment of the underlying disorder, and follow up care are important to assess. The command as well as professional mental health staff is integral to success with appropriate interventions.

**Ask, Care, and Escort**

Ask, Care, and Escort (ACE) is a program under the ASPP designed to identify and assist soldiers under duress to determine suicide behavior potential. The ACE program encompasses direct assessment of suicidal intent by peers. This program distributes cards to each soldier as an algorithm of risk factors and required action. This minimizes decision-making by possibly a young or inexperienced soldier (Table 3.1).

Suicide Prevention Task Force (SPTF) located on each installation has the responsibility to plan, implement, and manage its installation’s ASPP. The personnel roster for the SPTF is extensive and reflects the highly variable suicide risk factors leading to and associated with suicide (Table 3.2). The SPTF is tasked with analyzing the post’s suicides for trends as well as developing, evaluating, and modifying programs based upon needs of the community supported by the base. The SPTF can make recommendations to command elements to promote morale and has the autonomy to
### TABLE 3.1

**ASK, CARE, AND ESCORT PROGRAM**

<table>
<thead>
<tr>
<th>Ask</th>
<th>The Ask component involves having the soldier inquire about his or her buddy’s mental health status. Being direct and asking if suicide is being considered is a key component. This determination guides further needed intervention and could be highly subjective but overall it shows support or concern.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>Genuine interest and concern for the soldier in distress. Active listening is needed to understand the issue and intent. Ensuring the soldier remains safe by removing means of harm from the individual if needed, and if it is safe to do so. Force is discouraged.</td>
</tr>
<tr>
<td>Escort</td>
<td>Staying with the soldier in distress and taking the person to a mental health professional. These include chaplains, health behavior professionals, primary care professionals, or the unit leadership.</td>
</tr>
</tbody>
</table>

(U.S. Army Center for Health Promotion and Preventive Medicine, n.d.)
### TABLE 3.2
**SUICIDE PREVENTION TASK FORCE MEMBERS**

<table>
<thead>
<tr>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide prevention program manager</td>
</tr>
<tr>
<td>Alcohol drug control officer</td>
</tr>
<tr>
<td>Chaplain</td>
</tr>
<tr>
<td>Director of health services</td>
</tr>
<tr>
<td>Mental health officer</td>
</tr>
<tr>
<td>Public affairs officers</td>
</tr>
<tr>
<td>Director, human resources</td>
</tr>
<tr>
<td>Provost marshal</td>
</tr>
<tr>
<td>Commander, criminal investigations</td>
</tr>
<tr>
<td>Staff judge advocate</td>
</tr>
<tr>
<td>Army community services officer</td>
</tr>
<tr>
<td>Director of family, morale, welfare, and recreation</td>
</tr>
<tr>
<td>Director of plans and training</td>
</tr>
<tr>
<td>Representative of the post family member schools</td>
</tr>
<tr>
<td>Other organizational representatives as needed</td>
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</tbody>
</table>

(Department of the Army, 2010b)
set its own agenda. Lastly, there is a responsibility by the SPTF to be cognizant of the perceptions and publicity surrounding suicides for the post.

**Reduce the Stigma of Seeking Mental Health**

Those who need the care most are least likely to seek the care (U.S. Army, 2010). The caveat to seeking mental health care is perception of weakness. Mental illness is viewed as a manifestation of weakness or malingering and a threat to one’s career (Black et al., 2011). Within the military culture, mental toughness is viewed as a sign of strength and seeking mental health assistance can be viewed as weakness. The negative peer perception as a result of seeking mental health as well as the soldier’s own perception of self may act as barrier in mental health assistance. A recent survey reveals 51% of officers and enlisted personnel believe seeking assistance for mental health issues would have a negative impact on their career (U.S. Army, 2010).

This barrier is being eroded through policy and re-education of soldiers that seeking help is a sign of strength not weakness. Policies that discriminated against soldiers seeking mental health counseling are being eliminated. The security clearance application SF-86, question 21 has been modified to eliminate the need to disclose grief and family counseling (Lopez, 2010). Regulations are now in place that support prohibition of soldiers from belittling other soldiers who seek mental health care. The necessary efforts to educate the soldiers, family, and Department of the Army (DA) civilians about the common mental health issues that face soldiers are being implemented to enable a supportive environment. The culmination of supportive
policies leads to supporting confidentiality and normalizing mental health seeking behavior (Department of the Army, 2010b).

Postvention actions are taken to minimize the impact of a suicide or attempt. The actions are to minimize the psychological impact and mitigate copycat cases. The process relies on both effective communication and unit support from leadership. Communicating the suicide with respect but also with a cautious release of details to mitigate romanticizing the methods or the death is essential. Also, the leadership has the responsibility to maintain the strength, morale, and readiness of the unit during this time of loss.

According to Kuehn (2010), the Army considers primary care the best asset it has in identifying soldiers with mental health issues. The population, in general, is resistant to seeking assistance for mental health. Many soldiers see a primary care specialist or medical care before displaying suicidal behavior. Both military and non-military providers are essential. The provider is a key asset to ensuring that the comprehensive health care needs of soldiers can be met. In fact, the provider is identified as critical as a coordinator for soldiers with multiple comorbidities. Non-military providers are encouraged to familiarize themselves with the mental health issues in the military population. Some soldiers may seek care in their communities if they live off base, or are on leave or trying to avoid entering the system available on base. The providers should inquire about thoughts of suicide, PTSD symptoms, exposure to traumatic brain injury (TBI), and amount of substance usage.

The process of primary care providing care to mental health patients is being overhauled. Re-Engineering Systems of Primary Care Treatment in the Military
(RESPECT-MIL) is a process that enhances screening and treatment for mental health issues within the military primary care settings (Kuehn, 2010). RESPECT-MIL utilizes the current research on risk factors for the military population to create a lower threshold of sensitivity to detect mental health problems and offers the appropriate treatment (Table 3.3).

**Soldiers Responsibilities and Resiliency**

At the individual and interpersonal level, the soldier has responsibility for his or herself as well as for his/her cohort, affectionately named “battle buddy”. According to DA PAM 600-24, the soldier is responsible to live up to the Army Values (Appendix A) in caring for his/her buddy. In war, the Warrior's Ethos and Soldier's Creed both dictate a soldier is to never leave a fallen soldier behind, and thus, the Army is training as it expects to fight (Appendices B and C).

Comprehensive Soldier Fitness (CSF) is defined as the Army’s holistic program to assist soldiers with the appropriate skills to strengthen their ability to cope with life’s challenges (U.S. Army, 2010). The understanding is that resiliency is a life long journey and that a cookie cutter approach does not work. The Comprehensive Soldier Fitness Program was developed to provide resilience training for the U.S. Army and works to strengthen the five dimensions of strength: physical, emotional, social, spiritual, and family (Reivich, Seligman, & McBride, 2011; U.S. Army, n.d.b). There are four program elements; the Global Assessment Tool, Comprehensive Resilience Modules, Master Resilience Training, and Sustainment Resilience Training (Table 3.4). This program both enables and encourages soldiers to understand the how and why of what
TABLE 3.3

RECOMMENDATIONS FROM THE ARMY HEALTH PROMOTION, RISK REDUCTION, AND SUICIDE PREVENTION REPORT 2010

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Adopting protocols to screen soldiers with PTSD or mild traumatic brain injury for other mental health issues</td>
</tr>
<tr>
<td>Enhancing alcohol and drug abuse reporting and referral for treatment</td>
</tr>
<tr>
<td>Researching the impact of increased psychotropic drug use in military populations</td>
</tr>
<tr>
<td>Studying which antidepressants will treat anxiety and depression without elevating suicide risk</td>
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</table>

(Kuehn, 2010)
### TABLE 3.4
THE FOUR PROGRAM ELEMENTS OF THE COMPREHENSIVE SOLDIER FITNESS PROGRAM

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Global Assessment Tool is online and is to establish a baseline understanding of emotional, social, family, and spiritual dimensions and permits the soldier to evaluate personal growth.</td>
</tr>
<tr>
<td>2</td>
<td>Comprehensive Resilience Modules also online provides the informational material for the soldiers to utilize.</td>
</tr>
<tr>
<td>3</td>
<td>The Master Resilience Training is a 10-day interactive course taught to Non-Commissioned Officers (NCO). Comprised of preparation, sustainment, and enhancement, the course trains the trainers to enable the small unit leaders to deliver these skillsets to their troops.</td>
</tr>
<tr>
<td>4</td>
<td>Sustainment Resilience Training is delivered during the leadership schools based on the military life cycle and starting with initial entry and including pre, post and during deployment as well. This training is designed to prepare the soldier for the challenges they are about to face and overcome, with new lifelong coping skills.</td>
</tr>
</tbody>
</table>

(Reivich et al., 2011; U.S. Army, n.d.b.)
they think and to utilize the personal strengths they have to overcome in life (U.S. Army, n.d.b).

“Resiliency is the ability to recover and adapt despite adversity, trauma, illness, changes or misfortune” (Department of the Army, 2010b, p. 11). It is also defined as “bouncing back from difficult situations” (Department of the Army, 2010b, p. 11). In addition to having confidence in one’s abilities to function as a soldier, the Army considers the soldier’s resiliency a combination of factors starting with risk reduction by increasing individual protective factors. These suicide protective factors include improving social bonding and provision of mental, spiritual and physical health resources (Table 3.5). Important to mental health is a sense of belonging within the unit and the ability to connect with buddies. It is important that soldiers be able to maintain caring relationships, and possess the ability to manage strong feelings and impulses. In addition, the opportunity to access resources in time of need as well as for maintenance is key. Lastly, but an equally important component of resilience, is having the inner strength to face adversity and fears, which will occur regularly while maintaining a positive view of self.

BATTLEMIND stands for Buddies, Accountability, Targeted aggression, Tactical awareness, Lethally armed, Emotional control, Mission operational security, Individual responsibility, Non-defensive (combat) driving, and Discipline and ordering. This is now termed Resilience training. This was a first generation of assistance to soldiers to help with transitioning from deployment to home and the appropriate disposition of those defensive skills developed during deployment (Walter Reed Army Institute of Research U.S. Army Medical Research and Material Command, 2005).
TABLE 3.5  
MILITARY SUICIDE PROTECTIVE FACTORS AS DESCRIBED BY THE CENTER FOR DEVELOPMENTAL PSYCHOLOGY

<p>| | |</p>
<table>
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<tbody>
<tr>
<td>1.</td>
<td>Social support</td>
</tr>
<tr>
<td>2.</td>
<td>Leadership responsibilities</td>
</tr>
<tr>
<td>3.</td>
<td>Effective problem-solving</td>
</tr>
<tr>
<td>4.</td>
<td>Unit cohesion</td>
</tr>
<tr>
<td>5.</td>
<td>Access to assistant services</td>
</tr>
<tr>
<td>6.</td>
<td>Healthy lifestyle promotion</td>
</tr>
<tr>
<td>7.</td>
<td>Spiritual support</td>
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</tbody>
</table>

(Domenici, n.d.)
Development to cope and problem solve begins early in life and evolves with experience and maturity which can be highly variable. As coping skills vary, so does external support. For those with limited resources in either or both areas, life can be very challenging. The key is to somehow identify those at risk and offer support to get them over the crisis and create permanent change to prevent further self-destructive desires when faced with crises in the future.

Suicide protective factors (Table 3.6) specify adjuncts of life that promote hardiness (CDC, 2011c). These personal abilities and structures to survive and thrive are protective against self-harm. A sense of responsibility to family and having children in the home are protective elements against suicide (VISN 19 Mental Illness, Research, Education, and Clinical Center, 2009). The underlying theme is confidence, a sense of responsibility for something tangible, and adequate family and friends to lean on in time of need.

With so many risk factors, the support needed to prevent or decrease the leading producers of suicide such as mental illness, substance abuse, and previous suicide attempts must cross all strata’s of the socio-ecological model. In addition, those enabling factors such as availability of firearms and increased supply of prescription pain medications need to be mitigated.
<table>
<thead>
<tr>
<th>Protective Factor</th>
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<tbody>
<tr>
<td>Effective clinical care for mental, physical, and substance abuse disorders</td>
</tr>
<tr>
<td>Easy access to a variety of clinical interventions and support for help seeking</td>
</tr>
<tr>
<td>Family and community support (connectedness)</td>
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<tr>
<td>Support from ongoing medical and mental health care relationships</td>
</tr>
<tr>
<td>Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes</td>
</tr>
<tr>
<td>Cultural and religious beliefs that discourage suicide and support instincts for self-preservation</td>
</tr>
</tbody>
</table>

(CDC, 2011c)
Leadership and Discipline

Policy must be enforced in a manner that is just (U.S. Army, 2010). The unit level commander, provost marshal, and the Criminal Investigation Division (CID) govern the infraction depending on severity. The commander handles minor infractions, the provost marshal handles misdemeanors, and CID handles felonies. In addition, there are programs that assist with monitoring adverse troop behavior such as the Army Substance Abuse Program (ASAP) for drugs and alcohol abuse and the Family Assistance Program (FAP) for domestic issues.

According to the U.S. Army (2010), currently only 25% of young Americans are eligible to enlist in the military. Since 2004, 20% of new recruits required a waiver to enter into service for conditions that previously would have been disqualifying of service such as drug and alcohol issues and criminal convictions. Those individuals enlisting during time of war may seek out high-risk opportunities to satisfy a personal agenda. This subculture’s behavior has been tolerated for convenience and simply passed along. It is deemed critical to report the behavior and the soldier to address the matter and mitigate the associated problems. If necessary, chaptering a soldier due to maladaptive behavior is in the best interest of good order and discipline in many situations.
CHAPTER IV
ROLE OF THE ARMY PUBLIC HEALTH NURSE

While the APHN is not a substitute for a behavioral health practitioner, as nurses with advanced public health training, the APHN can provide assistance to behavioral health, command elements, and the soldier with suicide prevention strategies and information. Department of the Army Pamphlet 40-11 (DA Pam 40-11) was revised to capture the unique talents of the APHN to assist with suicide prevention. The APHN and the ASPP function on three levels of prevention which is the public health prevention model: primary, secondary, and tertiary prevention levels that match the prevention, intervention, and postvention model used by the ASPP (Wasserman & Durkee, 2009).

The vision of Army Public Health Nursing is to affect the behavior of soldiers leading to increased resilience (U.S. Army Medical Department, n.d.). Opportunities abound for the APHN to interact with soldiers who may be experiencing mental health challenges. Managing many of the Army's health-related programs such as the sexually transmitted infections (STI) program and the Army Family Advocacy Program (AFAP) positions the APHN to identify and engage those at risk for suicide. Also, hosting base wellness fairs and the more intimate unit education sessions provides the opportunity to interface with soldiers and to promote health to those at risk of disease and injury. Lastly, other roles assumed by the APHN involve participating in advising committees such as the Case Review Committee (CRC) for the AFAP and voting on actions. As members of committees, the APHN has an opportunity to identify soldiers and families in crisis as well as assess for suicide risk factors.
Army Regulation 40-11

According to the DA Pam 40-11’s (Department of the Army, 2009) Preventive Medicine updated Rapid Action Revision, the APHN is empowered to assist with the behavioral health aspect of suicides within the Army population. Table 4.1 gives a comprehensive list of the many functions of the APHN. These tasked roles give great latitude for the APHN to assist troops who may present with risk factors that contribute to suicidal behavior and may warrant intervention by behavioral health professionals. Components such as advocacy, making home visits, and the performance of health risk appraisals to identify both individual and aggregate health risks are talents and skillsets basic to an APHN. In addition, the APHN can assist with surveillance and support research, areas critically needing enhanced understanding to better serve those at risk of suicide (Headquarters Department of the Army, 2012).

Primary Prevention

Primary Prevention would consist of awareness, advocacy, and education to enhance protective factors and reduce risk factors (Wasserman & Durkee, 2009). Promoting universal suicide awareness to soldiers to offer support during challenging periods and show solidarity during this challenging time of their lives is essential. Also, important is for public health to provide awareness education regarding traumatic brain injury (TBI), PTSD, and other mental health issues, which will support behavioral health’s awareness campaign and Army goals. The APHN hosts the bases’ health promotion fairs and supports wellness endeavors through newspaper articles and presentations.
<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
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<tbody>
<tr>
<td>Conduct comprehensive community or population health assessments</td>
<td>Identify sub-populations, characterize their health, assess need for community health services, and identify available resources. Sub-populations include families and individuals at risk of illness, injury, disability, or premature death as well as those who could benefit from health promotion services.</td>
</tr>
<tr>
<td>Plan, develop, organize, implement, and evaluate health services</td>
<td>Based on community health needs, morbidity trends, and available resources.</td>
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<tr>
<td>Assist groups within the community to develop local health policies</td>
<td></td>
</tr>
<tr>
<td>Advocate for the special needs of individuals in the community setting</td>
<td>Provide home visits when warranted for health (to include behavioral) or safety assessments.</td>
</tr>
<tr>
<td>Train, monitor, and advise other health care personnel in community health and health promotion principles</td>
<td></td>
</tr>
<tr>
<td>Provide case management services in communicable and chronic diseases</td>
<td></td>
</tr>
<tr>
<td>Prescribe medications, x-rays, and laboratory studies as authorized</td>
<td></td>
</tr>
<tr>
<td>Serve as consultant to child and youth services staff as directed</td>
<td></td>
</tr>
</tbody>
</table>

(Department of the Army, 2009)
As a public health agent, awareness campaigns are a staple of the roles performed. The opportunity to inform the community of the suicide phenomenon is always welcomed. Advocacy is another role innate to the APHN, such as supporting policies to restrict lethal means and or other identified threats to soldier safety (Miller, 2012).

It is the APHN's responsibility to advocate for those deemed to be at risk of suicide as well as those in need of case management (Department of the Army, 2009). The APHN can assist by establishing relationships with commanders, family organizations, and other stakeholders of interest and by identifying units or jobs that have high numbers of soldiers with suicide risk factors. The APHN can tailor an approach targeting risk factors common to a job or unit to mitigate risk and promote resiliency to heal the soldiers. Also, the APHN can develop and advocate for programs to assist those in need of suicide prevention and intervention.

The APHN can provide the needed education to troops as well as their families in mass or individually about suicide prevention and the mental health assistance that is available. The U.S. Army Public Health Command website hosts information regarding suicide prevention that can be accessed by the soldier, command, or civilians (U.S. Army Public Health Command, n.d.). Materials such as handouts, media for viewing, and other information are available to assist both public health agents and the individual with questions regarding suicide prevention. The APHN can provide education and material to families of soldiers at health fairs, during patient visits, and upon request. Those families identified as high risk for soldiers with suicide risk especially could benefit from suicide prevention training. In addition, a unit, soldier, or family of a
soldier’s specific needs could be addressed by the APHN and the unit or soldier’s command informally. Minor allowances could reap large rewards for the unit, soldier and family members.

**Secondary Prevention/Intervention**

The goal of secondary prevention/interventions is early detection and treatment (Wasserman and Durkee, 2009). As a primary gatekeeper, the APHN has the responsibility to screen soldiers for suicide who appear as patients for tobacco cessation, STI, or other program management areas that may render the soldier in duress (Department of the Army, 2010a). Also, participating in the training of other soldiers to assist with identification of soldiers in crisis and management of their cohorts in times of need is vital.

**Screening**

With every medical contact an opportunity for behavioral health screening presents itself, and in some cases, the APHN may be the only member of the health care team the distressed soldier visits. The programs managed by APHNs put them in contact with individuals who may either be at immediate risk for suicide or may need behavioral services later. The tobacco cessation program, STI program, and other communicable or chronic diseases that the APHN may case manage are excellent opportunities to assess risk factors and suicide behavior risk. The U.S. Preventive Services Task Force (USPSTF) recommends screening of adults for depression
provided depression care supports are in place (U.S. Preventive Services Task Force, 2009).

A pilot study that examined nurse-facilitated depression screening reported an increase in the numbers of patients screening positive for depression from approximately 100 to approximately 130 per month with less than 3 minutes added to the patient process (Yackel, McKennan, & Fox-Deise, 2010). This model could be modified and extrapolated to the public health setting. Meeting the specific needs of soldiers at-risk remains the task of the mental health community; the APHN can competently identify those at-risk by identifying risk factors and assisting through referral for mental health assistance.

Through assessment of health risk appraisals and surveillance activities, the APHN can identify those units or military occupational specialties (MOS) on the installation where the greatest suicide risk dwells. At the local level, the APHN understands the population’s culture and thus can advise competently to commanders regarding risk. This could occur in real time and thus minimize suicide risk. The APHN can provide information to assist soldiers and commanders to recognize risk factors for suicide (Table 2.3) so they become an active part of early detection strategies.

**Tertiary Prevention/Postvention**

Tertiary prevention/postvention goals are to assist those soldiers that have been identified as suicide risks (Wasserman & Durkee, 2009). The APHN can assist by making home visits to barracks or residences to lend support to soldiers as they readjust. A local surveillance process offers the advantages of saving time from
diagnosis and data input, to tracking of cases and analysis of the affected sub-populations. Also, by tracking data at the local level, proximity of insight may reveal problems specific to a location not readily available from a global perspective.

**Homevisit**

When a soldier is seen as a patient by the APHN for a specific program-related care and is identified as high risk for suicide, the APHN can assist by escorting the patient to professional mental health care. Also, after a suicide attempt the APHN can assist in the process of preventing another attempt. Afterwards, follow up care can be conducted by the APHN. The APHN is empowered to conduct home visits to ensure the safety and health of soldiers is maintained (Department of the Army, 2009).

At some point, all soldiers identified at-risk for suicide leave the net of scrutiny. The APHN can assist with continued emotional support to those recently cleared of suicide risk. Through therapeutic communication and human connection, the APHN can use listening skills to help identify specific needs and concerns, and demonstrate a systematic concern for the soldier’s well being.

**Surveillance**

Through surveillance, units with elevated numbers of high-risk behavior could be identified. The Army currently uses the Army Suicide Event Report (ASER) to collect data on soldiers with completed suicides and suicide attempts. This epidemiological data collection tool is intended to assess the suicidal behaviors for trends and possibly
predictability of suicides (Gahm & Reger, 2011). This process addresses suicides and suicide-related behavior after it has occurred.

The APHN uses a system that may trend a sub-population that receives mental health drug prescriptions. Separate from the ASER reporting is the Electronic Surveillance System for the Early Notification of Community Based Epidemics (ESSENCE) used primarily by the Army’s public health section to assess for outbreaks. ESSENCE has a feature that tracks increases in prescription of specific pharmaceuticals to indicate possible outbreaks of disease. ESSENCE could be used to track increases in adverse mental health diagnoses and prescribed medication and thus risk factors for suicide. According to Hyman, Ireland, Frost, and Cottrell (2012), Selective Serotonin Reuptake Inhibitors (SSRI) may have a relationship with suicide incidence. The data generated by ESSENCE is usually aggregate, but it could be specified-dependent upon users authorization clearance and intent. The data could then be used to monitor for increases in SSRI dispensing as well as other mental health drugs and sleeping aids. The APHN could analyze the data to see if there are patterns of increased mental health diagnosis and antipsychotics and antidepressants use in relation to specific units, job types, or deployment cycles. The leadership of at-risk units could be assisted through education about high-risk behaviors and provide targeted information to those soldiers at risk. By using the currently existing surveillance system, the APHN could simply consider the additional suicide risk variables along with the influenza and bioterrorism indicators.
Future Research

The research options for further evaluation are based upon areas of possible underreporting. Mental illness, which is highly stigmatized, requires more queries into those in mental anguish overall and specifically regarding PTSD and TBI. Also, the relationships that are taxed by the strains of military life and situations established by those serving require further investigation and possibly mitigation. One area identified is the criterion of a soldier as either single or divorced and the relationship to suicide. There is scant research that addresses soldiers who are separated from their spouses or intimate ones and the potential for suicide. One article examining marital status, age, and gender uncovered a strong association with younger separated males and being at risk for suicide (Wyder, Ward, & De Leo, 2009).

Also, the degree of sexual and physical violence perpetrated among and within the service members should be investigated. While this is somewhat of a relatively new finding, more studies are indicated. What is understood at this point is there is a strong association of suicide with mental illness which could be a co-factor to suicide.

Lethal means restrictions, that is, restricting possession of personal firearms as a form of prevention within the military population, have been shown to be a benefit in other populations in decreasing suicide cases (Miller, 2012). RAND recommends a best practice to decrease suicide incidence within the military population (Appendix D). However, within the Army population, a force that readily relies on weaponry could be a challenge. Would this be a viable means of suicide prevention with this population?

According to the CDC, protective factors guard against suicide; however, the CDC acknowledges there is a lack of substantiated evidence involving protective factors
and recommends continued research (CDC, 2011c). With this gap in knowledge of what is a definitive protective factor, most suggestions have been speculative. Once evidenced-based research supports what is effective, policy and protocol can be developed with more confidence.

The USPSTF found suicide screening in primary care clinics of general population unequivocal (U.S. Preventive Services Task Force, 2004). More research is needed with clarification for the military population. Also, most literature available focuses on primary care clientele screenings. Specialty care clinics and their role with suicide prevention should be considered as options for suicide prevention.

Summary

The intended killing of one-self usually marks the end a period of suffering by the victim that most cannot relate to and do not experience. The families of the victims are left with a myriad of emotions and questions that may never be answered. The Global War on Terror, which began after the horrific events of September 11, 2001, brought about three wars that stretched the human fabric of our nation and exposed its weakest seams. In the two wars against terrorism, the Army was better prepared and every soldier was equipped to fight and win. The third war against mental health issues, revealed an ill prepared Army. However, the Army has adapted to assist its soldiers to engage this internal battle but there is much to do and a long way to go.

The effects of military life and combat, multiple deployments, and changes in recruiting standards all juxtaposed against the normal high stress life associated with American living has yielded unprecedented suicide rates in the U.S. military forces. The
U.S. Army is setting elevated trends for suicide incidence almost doubling its previous rate, and with the reduction in troop strength, that is, draw down of Iraq this year and in Afghanistan in 2014, this may only be the tip of the iceberg. The greatest adversary the U.S. Army may currently be engaging is within the minds of its troops and their behaviors.
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INTRODUCTION

The entrance point for all soldiers is initial entry training (IET) also known as basic training. Regardless of eventual job, all soldiers begin as a recruit. There, soldiers learn the guiding philosophies of the culture in which they have just entered: The Army Values, The Warrior Ethos and The Soldier’s Creed, all of which place the demand of a cause and purpose greater than oneself. Despite the stressor, amid the confusion, and regardless the unit, these mantras are a soldier’s orders.
APPENDIX A

THE ARMY VALUES

Loyalty

Bear true faith and allegiance to the U.S. Constitution, the Army, your unit and other Soldiers. Bearing true faith and allegiance is a matter of believing in and devoting yourself to something or someone. A loyal Soldier is one who supports the leadership and stands up for fellow Soldiers. By wearing the uniform of the U.S. Army you are expressing your loyalty. And by doing your share, you show your loyalty to your unit.

Duty

Fulfill your obligations. Doing your duty means more than carrying out your assigned tasks. Duty means being able to accomplish tasks as part of a team. The work of the U.S. Army is a complex combination of missions, tasks and responsibilities — all in constant motion. Our work entails building one assignment onto another. You fulfill your obligations as a part of your unit every time you resist the temptation to take “shortcuts” that might undermine the integrity of the final product.

Respect

Treat people as they should be treated. In the Soldier’s Code, we pledge to “treat others with dignity and respect while expecting others to do the same.” Respect is what allows us to appreciate the best in other people. Respect is trusting that all people have done their jobs and fulfilled their duty. And self-respect is a vital ingredient with the Army
value of respect, which results from knowing you have put forth your best effort. The Army is one team and each of us has something to contribute.

**Selfless Service**

Put the welfare of the nation, the Army and your subordinates before your own. Selfless service is larger than just one person. In serving your country, you are doing your duty loyally without thought of recognition or gain. The basic building block of selfless service is the commitment of each team member to go a little further, endure a little longer, and look a little closer to see how he or she can add to the effort.

**Honor**

Live up to Army values. The nation’s highest military award is *The Medal of Honor*. This award goes to Soldiers who make honor a matter of daily living — Soldiers who develop the habit of being honorable, and solidify that habit with every value choice they make. Honor is a matter of carrying out, acting, and living the values of respect, duty, loyalty, selfless service, integrity and personal courage in everything you do.

**Integrity**

Do what’s right, legally and morally. Integrity is a quality you develop by adhering to moral principles. It requires that you do and say nothing that deceives others. As your integrity grows, so does the trust others place in you. The more choices you make based on integrity, the more this highly prized value will affect your relationships with family and friends, and, finally, the fundamental acceptance of yourself.
Personal Courage

Face fear, danger or adversity (physical or moral). Personal courage has long been associated with our Army. With physical courage, it is a matter of enduring physical duress and at times risking personal safety. Facing moral fear or adversity may be a long, slow process of continuing forward on the right path, especially if taking those actions is not popular with others. You can build your personal courage by daily standing up for and acting upon the things that you know are honorable.

(U.S. Army, n.d.a)
APPENDIX B

WARRIOR ETHOS

I will always place the mission first.
I will never accept defeat.
I will never quit.
I will never leave a fallen comrade.

(U.S. Army, n.d.a)
APPENDIX C

SOLDIERS CREED

I am an American Soldier.
I am a warrior and a member of a team.
I serve the people of the United States, and live the Army Values.
I will always place the mission first.
I will never accept defeat.
I will never quit.
I will never leave a fallen comrade.
I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills.
I always maintain my arms, my equipment and myself.
I am an expert and I am a professional.
I stand ready to deploy, engage, and destroy, the enemies of the United States of America in close combat.
I am a guardian of freedom and the American way of life.
I am an American Soldier.

(U.S. Army, n.d.a)
The best practices identified by RAND are from an accumulation of research based on civilian settings. While remaining relevant, there are considerations specific to the active duty population. According to RAND, within the military there is overlap between health care and personnel systems. Exemplified are in patient observation versus unit watch. Also with the stigma of a mental illness, there are career ramifications such as being ostracized and loss of security clearances or for an officer or NCO, loss of command or leadership opportunities (Ramchand et. al., 2011).

**Raise Awareness and Promote Self Care**

Endorsed by the RAND research is a reduction of risk factors and skill building to cease suicidal thoughts. These are very important tools, especially for those with a history of previous suicide attempts.

**Identify Those at High Risk**

Through the use of gatekeepers or primary care personal identifying those at risk for suicidal behaviors.

**Facilitate Access to Quality Care**

Reducing barriers to mental health care and improving access to mental health care.
**Provide Quality Care**

Specialized suicide care is needed to address those with identified suicidal risk factors. As well as generalized mental health care, for those experiencing mental health issues and can be assisted before suicidal behavior development.

**Restrict Access to Lethal Means**

This challenging aspect due to constitutional right as well as “tool of the trade” for many military personnel does not have a neat remedy.

**Respond Appropriately**

Showing respect for the deceased in concurrence with managing a public response. This requires that both require provision of information of the passing to peers and family as well as satisfactory public statement.