Suicide and Service Members:

Suicide Increases While Combat Decreases

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Abstract

This paper explores the risk factors, reasons, and solutions to the suicide rate among military service members and veterans with a concentration on 2011 statistics of United States Army service members. The suicide rate among military service members and veterans has increased from the year 2001 through 2012 although combat specifically has decreased. This paper examines the data provided in the Department of Defense (DOD) for the Department of Defense Suicide Evaluation Report (DODSER), *Calendar Year 2011 Annual Report* (2012) as well as other articles to suggest that implementation of better suicide prevention programs by the Army and other Department of Defense services, as well as programs for friends and family of service members, will positively influence a lower suicide rate among service members and veterans. It has also been noted that the reduction of stigma against mental illness and seeking help must continue to be reduced in order to lessen the rates of suicide. Research was conducted with online sources (Internet) and offline sources (non-Internet).

Keywords: military suicide, suicide prevention

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Active duty Army averaged 80.77 self-inflicted deaths per year between 2001 and 2009, where Army Reserve and National Guard averaged 16.33 deaths per year. In contrast, 2011 alone had 287 incidents that were reported across the services with Army in the lead at 167, Navy next with 52, Air Force third with 50, and the Marine Corps coming in at 32. (Luxton et al., 2012) (See Table 1)

"The United States will maintain more than 60,000 troops in Afghanistan through the spring and summer fighting season, cutting to 34,000 by February and staying at that strength through the Afghan elections set for 2014," said Defense Secretary Leon E. Panetta. (Parrish, 2013) With troops now out of Iraq completely, and drawing down in Afghanistan after over ten years of war, more and more service members are coming home and trying to adjust to a 'normal' post-war life. "Looking back I remember things before going to Iraq and after. Kind of like BC and AD in history," said Sarah Smith, Operation Iraqi Freedom (OIF) II veteran in a personal interview. (Smith, 2013)

The majority of the data posted in this paper comes from the official 2011 data submitted DOD for the DODSER, *Calendar Year 2011 Annual Report*. This report is very detailed and includes data from all aspects of a person's life and history from demographic data, which includes level of education completed, to the mode of communication (i.e. suicide letters or text messages) and the method of suicide. Other data sources include official Army websites and a military newspaper, *Stars and Stripes*.

Stigma of mental illness is defined as "devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses." (Abdullah & Brown, 2011) Social distances

between the mentally healthy and mentally ill have existed for centuries throughout the world and across all cultures. Most stereotypes and perception is that a person suffering from mental illness is dangerous and instead of turning to them to offer help, most will turn away. While much work is being done to close the gap and change the stigma of mental illness and a lot of progress has been made this century, stigma and stereotypes remain a big reason that many people with mental illness do not seek treatment.

This same perception of mental illness by service members not suffering from mental illness is no exception. Many service members who suffer from mental illness do not seek treatment. “The internalization of these negative beliefs results in self-stigma, leading to reduced self-esteem and motivation to seek help.” (Britt, Greene-Shortridge & Castro, 2007) In the video *Suicide Prevention and Stigma Reduction Message* by Sergeant Major of the Army Raymond F. Chandler III, he insists to “encourage your soldiers to seek help. Recognize that seeking help is a sign of courage and that even the strongest turn to one another in a time of need.” (Army G1, 2011) Taking the warning signs exhibited by soldiers seriously is also very important. “So many people saw warning signs with me and I just got grief and pegged as a bad soldier,” Sergeant Hollie Chapman, a veteran of Operation Enduring Freedom (OEF) VII said in a personal interview when asked about events leading up to cutting herself to relieve pressure from stress. Chapman has personally struggled with severe Post Traumatic Stress Disorder (PTSD). (Chapman, 2013)

Risk factors of suicide include medical history, existing family life issues, military status, deployment to austere environments, lack of training on suicide prevention, and lack of treatment availability. Suicide does not consume only those with lower education, six of the 301 suicides in 2011 had masters degrees or higher. (See Table 2)

Less than half of the 2011 decedents had a medical history of at least one documented behavioral health disorder. According to DODSER it is reported that 935 suicide attempts by 915 individuals occurred in 2011 spanning across all DOD services. DODSER standardizes suicide surveillance efforts across the services (Air Force, Army, Marine Corps, and Navy) to support the DOD's suicide prevention mission. 896 service members attempted suicide once, 18 attempted suicide twice, one attempted three times, and one service member successfully died after multiple attempts were made. (Luxton et al., 2012) This signals that there is disconnect between reaching out for help and actually receiving it. (See Table 3)

There are many factors and risks of suicide. "One-fourth of Service members who died by suicide had a known history of substance abuse." (Luxton et al., 2012) 16% received substance abuse treatment in 2011. Many decedents had existing family life issues to include financial problems, marital or relationship problems, and disciplinary issues. Economic hardship is another factor contributing to suicide. 21% of the service members who died by suicide in 2011 had either lost a position or experienced job instability, and 25 service members (8.7%) had experienced significant debt. (Luxton et al., 2012) (See Table 4)

The marital status of decedents in 2011 included 167 married, 23 divorced, 107 never married, and 4 widowed. Of the married service members, 82 resided with their spouse, 38 were separated due to relationship issues, 14 were apart for other reasons or deployed, and 8 had no data. Nearly half of the service members were reported to have had a history of a failed marital or intimate relationship with half of those being within 30 days of death. (See Table 5)

The majority of suicides in 2011 and most other years were by service members under the age of twenty-five, were junior enlisted service members (rank E1-E4), male caucasian, and had a high school education.10 service members in 2011 had a history of courts martial, 18% had

history of Article 15 or non-judicial punishment, 12% (37 cases) had history of civil legal problems, and 37% had other administrative/legal issues. (See Table 6)

Almost half of the decedents in 2011, 134 individuals, had deployment history of OEF, OIF, or Operation New Dawn (OND) with 15% having a known history of direct combat experience within the three most recent deployments. Only 28 suicides actually occurred in theater of operations (Afghanistan or Iraq.) (Luxton et al., 2012) (See Table 7)

Some soldiers have a hard time adjusting to life in the military and life while deployed to overseas contingency operations such as Afghanistan and Iraq. Many soldiers do not want to be involuntarily deployed once, let-alone multiple times, and the negative effects of these stressors on those who have difficulty with coping is magnified and has sometimes lead to suicidal thoughts and actions. Some soldiers want to be deployed for different reasons. One reason is the financial benefit of being deployed with the extra pay for hazardous duty or combat zone, tax-free earnings up to a certain amount, and a small amount of per-diem entitlements, which add up to a chunk of money at the end of tour. A lot of lower ranking service members depend on deployment money to support their family. With the drawdown of troops overseas post-conflict, many aren't seeing more deployment time and feel the financial hardship leading to difficulties in relationships and other emotional issues.

Of the 44 service members with history of direct combat experience, six were injured in combat, 16 witnessed killing in combat, 15 saw dead bodies in combat, and 6 killed others in combat. (Luxton et al., 2012) Guilt of deployment experiences plays a role in suicide of military service members. Many come back feeling guilty of their part in combat or suffer from wishing it were them who were killed rather than a buddy. The intensity of combat operations overseas makes a difference too. Nine decedents (3.14%) in 2011 had previously diagnosed with

Traumatic Brain Injury (TBI). (Luxton et al., 2012) Studies are being conducted on the relationship between mild traumatic brain injury and suicide. “Evidence has suggested that blast injuries, including but not limited to those causing damage to vision or hearing, can have a severe psychological impact, contributing to PTSD and other emotional distress that can play a major contributing role in suicides.” (Benishek et al., 2013) Although deployments play a major factor in risks of suicide, the majority of suicides in 2011 were of service members who had never deployed. (See Table 8)

David Rudd, co-founder and scientific director of the National Center for Veteran Studies based at the University of Utah tells *NBC News* that this new generation of Soldiers is part of the ‘Self-esteem generation.’ “This group is the self-esteem generation. My worry is they have not dealt with enough challenges, enough disappointments in life for many of them to build the kind of resilience that is foundational when you go to war. This has led to many of us to having thin skin. That doesn’t bode well when you go to war.” (Briggs, 2013)

Difficulty reintegrating into ‘normal life’ provides another barricade to overcome for many veterans. Kim Ruocco leads the suicide prevention program for a group called Tragedy Assistance Program for Survivors and tells Tampa Bay Online that, "Now that we're decreasing our troops and they're coming back home, that's when they're really in the danger zone, when they're transitioning back to their families, back to their communities and really finding a sense of purpose for themselves," Ruocco’s husband killed himself between Iraq deployments in 2005. (TBO.com, 2013)

Of the 934 suicide attempts in 2011 reported to DODSER, 588 service members intended to die, 149 did not intend to die, and 197 no data is provided on intent to die. Of the successful suicides in 2011, 173 intended to die and 26 did not. 59 decedents died in a location where it was

possible other people could have witnessed the suicide. This shows that at least 149 individuals used a suicide attempt to reach out for help. (See Table 9)

Of the 40% service members who had received outpatient behavioral healthcare prior to suicide, 16.72% received treatment within the month prior to suicide. 14.98% received inpatient behavioral health treatment with 3.83% receiving treatment also within the month prior to their self-inflicted death. Availability of treatment used to be a concern, but over the past several years many resources have become available to service members including incorporating mental health professionals on the front lines of combat and providing mental health evaluations at certain time intervals after deployment has ended.

Many soldiers are afraid to speak out about how they are feeling. When speaking about his brother's suicide one month after returning from an OEF deployment, Shane Barrett says, "from talking to a couple of other guys in his unit, he didn't want to come forward (to seek mental-health help) because you'd be red-flagged. It would be your exit out of the Army ... The guys in the Army are just flat-out afraid to come forward." (Briggs, 2013) The services need to address soldiers' feelings of repercussions for going forward with mental health services and help. According to Lieutenant Colonel Joe Scrocca of the 2nd Infantry Division in South Korea, "There is nothing official or unofficial that would lead to discharging someone for a suicide ideation… It has nothing to do with the re-enlistment process." (Reed, 2012)

The U.S. Army suicide prevention program's mission is to improve readiness through the development and enhancement of the Army Suicide Prevention Program policies designed to minimize suicide behavior; thereby preserving mission effectiveness through individual readiness for Soldiers, their Families, and Department of the Army civilians. Suicide prevention training also needs to change and is slowly doing so. For years and years the Army has used

boring power point slides and content in the annual mandatory suicide prevention training for active duty and reserve component soldiers. When asked what the Army can do to help soldiers in distress, Chapman said, "Senior leadership need to be aware of intensive emotion. The worst part for me was being pegged as a bad soldier due to my emotions and outburst. All that did was make me more emotional 'cause at that point I was labeled a s***bag! ... It was unfair 'cause it just made what I was going through worse. I think using soldiers with real experiences, that have been there and gotten help, would be more effective than some officer reading out of a book." (Chapman, 2013) Sergeant Timothy Wallace, U.S. Army veteran of OEF IX, speaks of the improving quality in suicide awareness training: "I saw the best video yet this past deployment return because it had real life people who have lost someone they love to suicide and it draws your attention to the fact that this is preventable with medicines and a good support group." (Wallace, 2013)

Avionics/Electrical Technician 3rd Class Petty Officer (AET3) Satya Ciulla, U.S. Army veteran of OIF II currently serving in the U.S. Coast Guard would like to see more personal instruction involved in the training, "I have to take suicide prevention training every year in the Coast Guard... I'd rather be in a class session where maybe the teacher/instructor has first hand experience with suicide attempts." (Ciulla, 2013)

Mary Lopez is a retired Army colonel who developed the program Soldier 360. Soldier 360 targets noncommissioned officers, or NCOs, who have combat experience. The course lasts two weeks and offers comprehensive training in stress and anger management, biofeedback, relaxation, yoga, meditation, physical fitness and conditioning, injury prevention, pain management, relationships, communication, conflict resolution, nutrition, sleep, combat stress, post-traumatic stress, and alcohol management. (Makle, 2011) "My wife and I communicate a

lot more now. We spend a lot more time together, and at work I can listen to Soldiers with more compassion. I try to understand their problems. I put myself in their position. That is something I didn't do before," says Sergeant First Class Milton Johnson III, a Soldier 360 alumnus in Grafenwoehr Germany. (Makle, 2011) 90% of suicides between 2001 and 2009 had the risk factor of high stress loads. Additional focus on alleviating the proximal risk factors for suicide (e.g., stress and psychopathology) could enhance this reduction. (Black, Gallaway, Bell & Ritchie, 2011) Implementing Soldier 360 and resilience training in an interesting way could prove to appeal to service members and lower this risk factor.

What seems to make the most difference in prevention is educating service members who are not suffering from mental illness or suicidal thoughts to recognize the warning signs of others and to actually step forward with assistance to the soldier contemplating ending his or her life. "The piece I really focus on is what we call collective responsibility. If something doesn't look right next to you, ask the question. Don't wait." Major General Edward Cardon says. (Zoroya, 2013) Not all decedents had prior history of self-inflicted injury before suicide. (See Table 10)

Air Force Captain Yvonne Levardi makes a good point about knowing those around you, "We can go to seminars and read brochures forever, but the bottom line is we won't know if someone is considering suicide unless we truly get to know that person." (Caruso) More often than not, decedents didn't appear to friends and family to have any warning signs leading up to their death but in retrospect the signs are all there. Sabrina Gilley, ex-wife of Captain Thomas Gilley of the Tennessee National Guard told The Knoxville News-Sentinel after Gilley committed suicide that, "I don't know if anything would have prevented it. But I think if they did some kind of class for relatives on what to look for, that would help. You can't just send him home to his family and expect us to fix him." (Lakin, 2013) Reports of suicidal thoughts or

gestures among 2nd Infantry Division have increased but actual attempts have decreased according to Lieutenant Colonel Joe Scrocca. He said, “while the initial ideations are going up, awareness is also up … people [are] recognizing soldiers who need help early on and then helping them get it.” (Reed, 2012) In this same command about 80 percent of the prevention is attributed to non-professionals rather than mental health professionals or chaplains, Scrocca said. (Reed, 2012)

Courage to Care is a health campaign of the Uniformed Services University of the Health Sciences and the Center for the Study of Traumatic Stress. Courage to Care highlights an informational sheet for military families and stresses, “the more you know, the more likely you are to identify warning signs and to help prevent the loss or injury of a loved one.” (USUHS, CSTS)

There are resources available to the general public for education in suicide prevention. The United States Army Public Health Command has products available on their website to educate families in suicide prevention with tip cards in risk factors and warning signs for families, family coping and resiliency (See Appendix Figure 1) (USAPHC, 2011), and the DOD Family ACE Card (See Appendix Figure 2). (USAPHC, 2010)

The official U.S. Army’s suicide prevention program lists resources available to soldiers. The list includes calling emergency 911, phone numbers for the Military Crisis Line, National Suicide Prevention Lifeline, Military One Source, The Defense Center of Excellence, Wounded Soldier and Family Hotline, and a link to Real Warriors Campaign. The suicide prevention program’s website also highlights an article to mobile applications that help you relax, and the Army Suicide Awareness Guide for Leaders. There is a plethora of assistance for military service members, regardless of veteran status. Resources span from mental health assistance to

reintegration help into civilian or non-combat lifestyle and employment placement services.

To conclude, while the conflicts of Iraq, Afghanistan and other locations draw down service members are struggling to overcome challenges they face from their experiences and burdens. More and more programs are made available to service members and veterans to help with coping with the rigors and aftermath of deployments, help with job placement, and financial counseling and assistance to name a few. Most importantly, recommendations to combat suicide in the military require a solution of de-stigmatizing mental illness and to better educate friends and family of service members and veterans in identifying risk factors and telltale signs of potential suicidal attempt, and strongly encouraging those suffering to seek help. Basically: step up, be nosey, and get them help even if they insist they don't need it. Don't assume someone else will do it; it may save their life.

Glossary

AET3:	Avionics/Electrical Technician 3rd Class Petty Officer
AFMES:	Armed Forces Medical Examiner System
AD:	Anno Domini
BC:	Before Christ / Before Common Era
CY:	Calendar Year
DMDC:	Defense Manpower Data Center
DOD:	Department of Defense
DODSER:	Department of Defense Suicide Event Report
NCO:	Non-Commissioned Officer (Enlisted ranks E-5 to E-9)
OEF:	Operation Enduring Freedom (Afghanistan)
OIF:	Operation Iraqi Freedom (Iraq)
OND:	Operation New Dawn
PTSD:	Post-Traumatic Stress Disorder
TBI:	Traumatic Brain Injury

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Table 1

CY 2011 AFMES and DMDC Demographic Data for Suicides by Service (Luxton et al., 2012)

	AIR FORCE				ARMY				MARINE CORPS				NAVY			
	Suicide		Service	Rate/	Suicide		Service	Rate/	Suicide		Service	Rate/	Suicide		Service	Rate/
	Count	Percent	Total %	100K	Count	Percent	Total %	100K	Count	Percent	Total %	100K	Count	Percent	Total %	100K
TOTAL	50	100.00%	100.00%	13.27	167	100.00%	100.00%	22.90	32	100.00%	100.00%	14.87	52	100.00%	100.00%	14.98

Table 2

CY 2011 and 2009-2010 AFMES and DMDC Demographic Data for Suicides (Cont.) (Luxton et al., 2012)

		2011				2010		2009		2008	
		Suicide		DoD Total	Rate/	Percent	Rate/	Percent	Rate/	Percent	Rate/
		Count	Percent	%	100K		100K		100K		100K
EDUCATION	Some high school, did not graduate	**5**	**1.66%**	0.59%	*	0.68%	*	0.65%	*	3.36%	*
	GED	**32**	**10.63%**	4.51%	**42.51**	8.81%	29.91	14.24%	45.21	8.96%	24.10
	High school graduate	**194**	**64.45%**	61.85%	**18.79**	69.83%	19.77	67.64%	20.01	63.43%	16.40
	Some college or technical school	**16**	**5.32%**	2.45%	*	5.08%	*	5.18%	*	1.49%	*
	Degree/certificate less than four years	**18**	**5.98%**	8.93%	*	6.10%	*	2.91%	*	9.33%	*
	Four-year college degree	**22**	**7.31%**	10.51%	**12.54**	6.10%	*	5.50%	*	7.46%	*
	Master's degree or greater	**6**	**1.99%**	8.39%	*	1.02%	*	2.91%	*	5.97%	*
	Don't Know	**8**	**2.66%**	2.77%	*	2.37%	*	0.97%	*	0.00%	*

Table 3
CY 2011 and 2010 DOD Suicide Attempt DODSERS (Luxton et al., 2012)

		Count	Percent
TOTAL SUICIDE ATTEMPT DoDSERs		935	100.00%
TOTAL INDIVIDUALS INCLUDED		915	100.00%
SUICIDE ATTEMPT DoDSERs SUBMITTED PER INDIVIDUAL	1	896	97.92%
	2	18	1.97%
	3	1	0.11%
INDIVIDUALS WITH 2011 DoDSERs FOR BOTH SUICIDE ATTEMPT AND SUICIDE		1	0.11%

Table 4
CY 2011 and 2009-2010 DODSER Financial and Workplace Difficulties (Luxton et al., 2012)

		2011		2010	2009
		Count	Percent	Percent	Percent
EXCESSIVE DEBT/BANKRUPTCY	Yes	25	8.71%	9.96%	10.77%
	No	137	47.74%	57.65%	54.55%
	Don't Know	125	43.55%	32.38%	34.68%
HX JOB LOSS/INSTABILITY	Yes	61	21.25%	18.51%	27.27%
	No	141	49.13%	58.36%	51.18%
	Don't Know	85	29.62%	23.13%	21.55%
HX SUPERVISOR/COWORKER ISSUES	Yes	30	10.45%	12.46%	14.14%
	No	160	55.75%	62.28%	60.61%
	Don't Know	97	33.80%	25.27%	25.25%
HX POOR WORK EVALUATION	Yes	46	16.03%	14.23%	16.84%
	No	156	54.36%	62.63%	62.63%
	Don't Know	85	29.62%	23.13%	20.54%
HX UNIT/WORKPLACE HAZING	Yes	3	1.05%	1.78%	1.68%
	No	182	63.41%	74.02%	70.37%
	Don't Know	102	35.54%	24.20%	27.95%

Table 5
CY 2011 and 2009-2010 DODSER Failed Relationships Prior to Suicide (Luxton et al., 2012)

		2011		2010	2009
		Count	Percent	Percent	Percent
HX FAILED INTIMATE RELATIONSHIP	Yes	**134**	**46.69%**	49.82%	50.84%
	Within 30 days	**79**	**27.53%**	29.89%	27.61%
	Within 90 days (inclusive)*	**99**	**34.49%**	35.94%	34.68%
	No	**68**	**23.69%**	29.89%	25.25%
	Don't Know	**85**	**29.62%**	20.28%	23.91%
HX FAILED OTHER RELATIONSHIP	Yes	**26**	**9.06%**	14.59%	13.47%
	Within 30 days	**14**	**4.88%**	8.54%	8.08%
	Within 90 days (inclusive)*	**19**	**6.62%**	10.32%	9.09%
	No	**123**	**42.86%**	49.82%	47.81%
	Don't Know	**138**	**48.08%**	35.59%	38.72%
HX ANY FAILED RELATIONSHIP (INTIMATE AND/OR OTHER)	Yes	**142**	**49.48%**	53.02%	53.54%
	Within 30 days	**83**	**28.92%**	33.45%	29.63%
	Within 90 days (inclusive)*	**105**	**36.59%**	39.50%	36.70%
	No	**60**	**20.91%**	26.69%	23.91%
	Don't Know	**85**	**29.62%**	20.28%	22.56%

*Data presented for "Within 90 days" includes all individuals with history "Within 30 days."

Table 6
CY 2011 and 2009-2010 DODSER Administrative and Legal History (Luxton et al., 2012)

		2011		2010	2009
		Count	Percent	Percent	Percent
HX COURTS MARTIAL	Yes	10	3.48%	6.41%	6.40%
	No	208	72.47%	74.38%	79.46%
	Don't Know	70	24.39%	19.22%	14.14%
HX ARTICLE 15 OR NON-JUDICIAL PUNISHMENT	Yes	52	18.12%	21.35%	17.17%
	No	160	55.75%	60.50%	66.33%
	Don't Know	75	26.13%	18.15%	16.50%
HX ADMIN SEPARATION	Yes	20	6.97%	9.25%	8.42%
	No	197	68.64%	72.24%	77.78%
	Don't Know	70	24.39%	18.51%	13.80%
HX AWOL	Yes	18	6.27%	8.19%	10.10%
	No	203	70.73%	74.02%	77.44%
	Don't Know	66	23.00%	17.79%	12.46%
HX MEDICAL BOARD	Yes	17	5.92%	5.34%	8.08%
	No	207	72.13%	80.78%	79.46%
	Don't Know	63	21.95%	13.88%	12.46%
HX CIVIL LEGAL PROBLEMS	Yes	37	12.89%	13.17%	12.12%
	No	162	56.45%	64.06%	65.32%
	Don't Know	88	30.66%	22.78%	22.56%
HX NON-SELECTION FOR PROMOTION	Yes	16	5.57%	6.41%	7.74%
	No	187	65.16%	72.24%	74.07%
	Don't Know	84	29.27%	21.35%	18.18%
HAD ANY ADMIN/LEGAL ISSUE	Yes	107	37.28%	42.70%	41.08%
	No	117	40.77%	39.50%	43.10%
	Don't Know	63	21.95%	17.79%	15.82%
HAD MULTIPLE ADMIN/LEGAL ISSUES	Yes	42	14.63%	17.44%	17.51%
	No	182	63.41%	37.37%	41.08%
	Don't Know	63	21.95%	45.20%	41.41%

Table 7
CY 2011 and 2009-2010 DODSER Suicides in Theater (Luxton et al., 2012)

		2011		2010	2009
		Count	**Percent**	Percent	Percent
THEATER	Afghanistan	**18**	**6.27%**	6.05%	2.36%
	Iraq	**10**	**3.48%**	4.27%	10.44%
	Djibouti	**0**	**0.00%**	0.36%	0.00%
	Kuwait	**0**	**0.00%**	0.00%	0.34%
	Not OEF/OND	**258**	**89.90%**	89.32%	86.87%

Note: One Service Member located Shipboard as part of OND

Table 8
CY 2011 and 2009-2010 DODSER Suicides in Theater (Luxton et al., 2012)

		2011		2010	2009
		Count	**Percent**	Percent	Percent
HX DEPLOYMENT OEF/OIF/OND	Afghanistan	**42**	**14.63%**	11.39%	3.70%
	Iraq	**65**	**22.65%**	27.05%	37.71%
	Kuwait	**4**	**1.39%**	1.07%	3.03%
	Multiple OEF/OIF/OND locations	**23**	**8.01%**	6.41%	7.07%
	No history of OEF/OIF/OND deployment	**153**	**53.31%**	54.09%	48.48%

Table 9
CY 2011 and 2009-2010 DODSER Additional Event Information (Luxton et al., 2012)

		2011		2010	2009
		Count	**Percent**	Percent	Percent
INTENDED TO DIE	Yes	**173**	**60.28%**	71.53%	76.09%
	No	**26**	**9.06%**	8.19%	5.39%
	Don't Know	**87**	**30.31%**	20.28%	18.52%
OBSERVABLE	Yes	**59**	**20.56%**	22.78%	20.54%
	No	**165**	**57.49%**	63.35%	68.69%
	Don't Know	**63**	**21.95%**	13.88%	10.77%

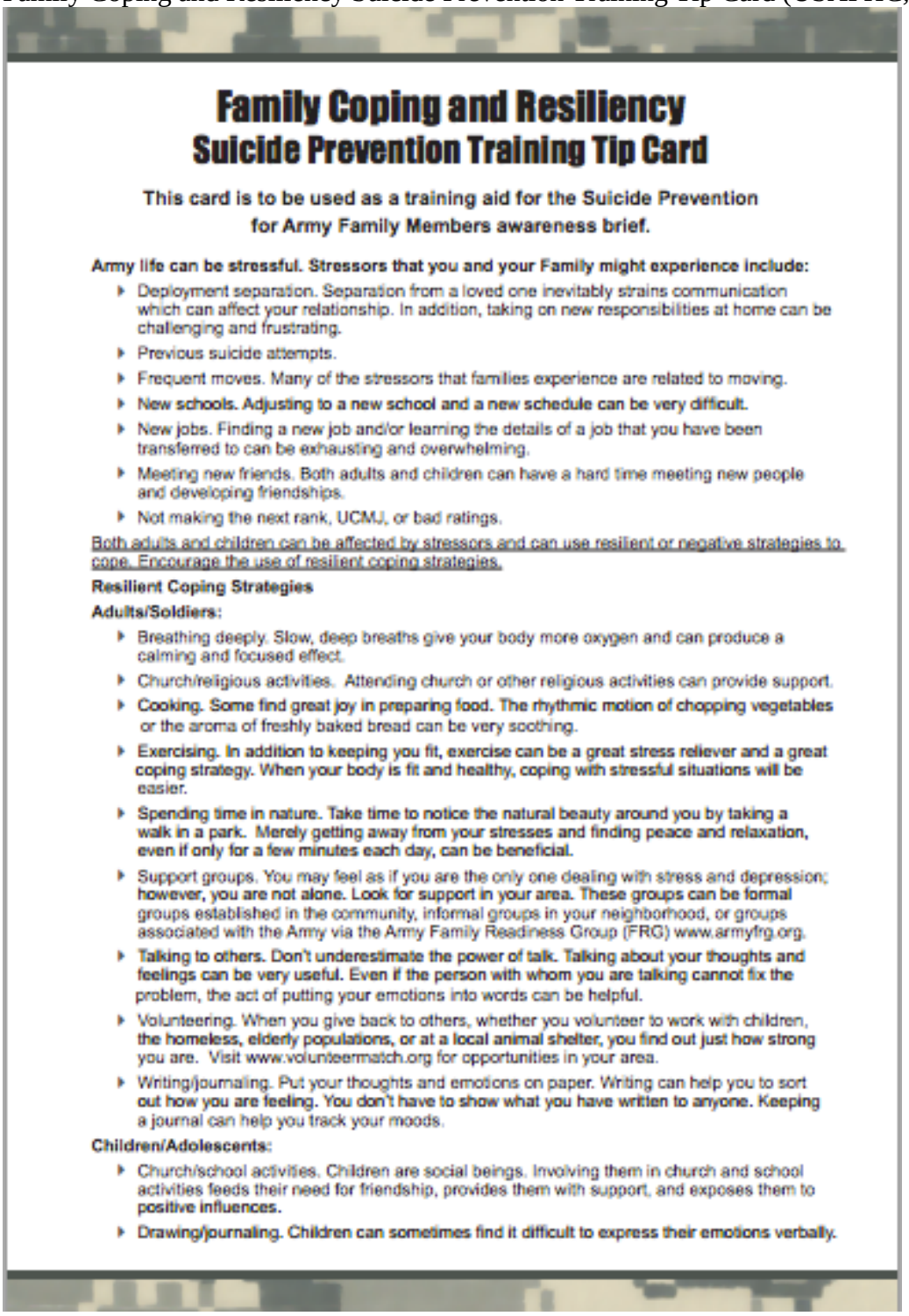
Table 10
CY 2011 and 2009-2010 DODSER Prior Self Injury (Luxton et al., 2012)

		2011		2010	2009
		Count	**Percent**	Percent	Percent
HX PRIOR SELF-INJURY	Yes	**38**	**13.24%**	13.52%	17.17%
	Within 30 days	**5**	**1.74%**	1.07%	4.04%
	Within 90 days (inclusive)*	**10**	**3.48%**	2.85%	7.74%
	No	**143**	**49.83%**	61.57%	58.25%
	Don't Know	**106**	**36.93%**	24.91%	24.58%
Number prior self-injuries	One prior event	**18**	**6.27%**	7.83%	10.10%
	More than one prior event	**20**	**6.97%**	5.69%	7.07%
	N/A or Unknown	**249**	**86.76%**	86.48%	82.83%
Event similar to prior self-injury	Yes	**13**	**4.53%**	3.20%	3.03%
	No	**21**	**7.32%**	8.90%	10.10%
	Don't Know	**5**	**1.74%**	1.42%	4.04%
	N/A	**249**	**86.76%**	86.48%	82.83%

*Data presented for "Within 90 days" includes all individuals with history "Within 30 days."

Appendix

Figure 1
Family Coping and Resiliency Suicide Prevention Training Tip Card (USAPHC, 2011)



Family Coping and Resiliency
Suicide Prevention Training Tip Card

This card is to be used as a training aid for the Suicide Prevention for Army Family Members awareness brief.

Army life can be stressful. Stressors that you and your Family might experience include:

- Deployment separation. Separation from a loved one inevitably strains communication which can affect your relationship. In addition, taking on new responsibilities at home can be challenging and frustrating.
- Previous suicide attempts.
- Frequent moves. Many of the stressors that families experience are related to moving.
- **New schools. Adjusting to a new school and a new schedule can be very difficult.**
- New jobs. Finding a new job and/or learning the details of a job that you have been transferred to can be exhausting and overwhelming.
- Meeting new friends. Both adults and children can have a hard time meeting new people and developing friendships.
- Not making the next rank, UCMJ, or bad ratings.

Both adults and children can be affected by stressors and can use resilient or negative strategies to cope. Encourage the use of resilient coping strategies.

Resilient Coping Strategies

Adults/Soldiers:

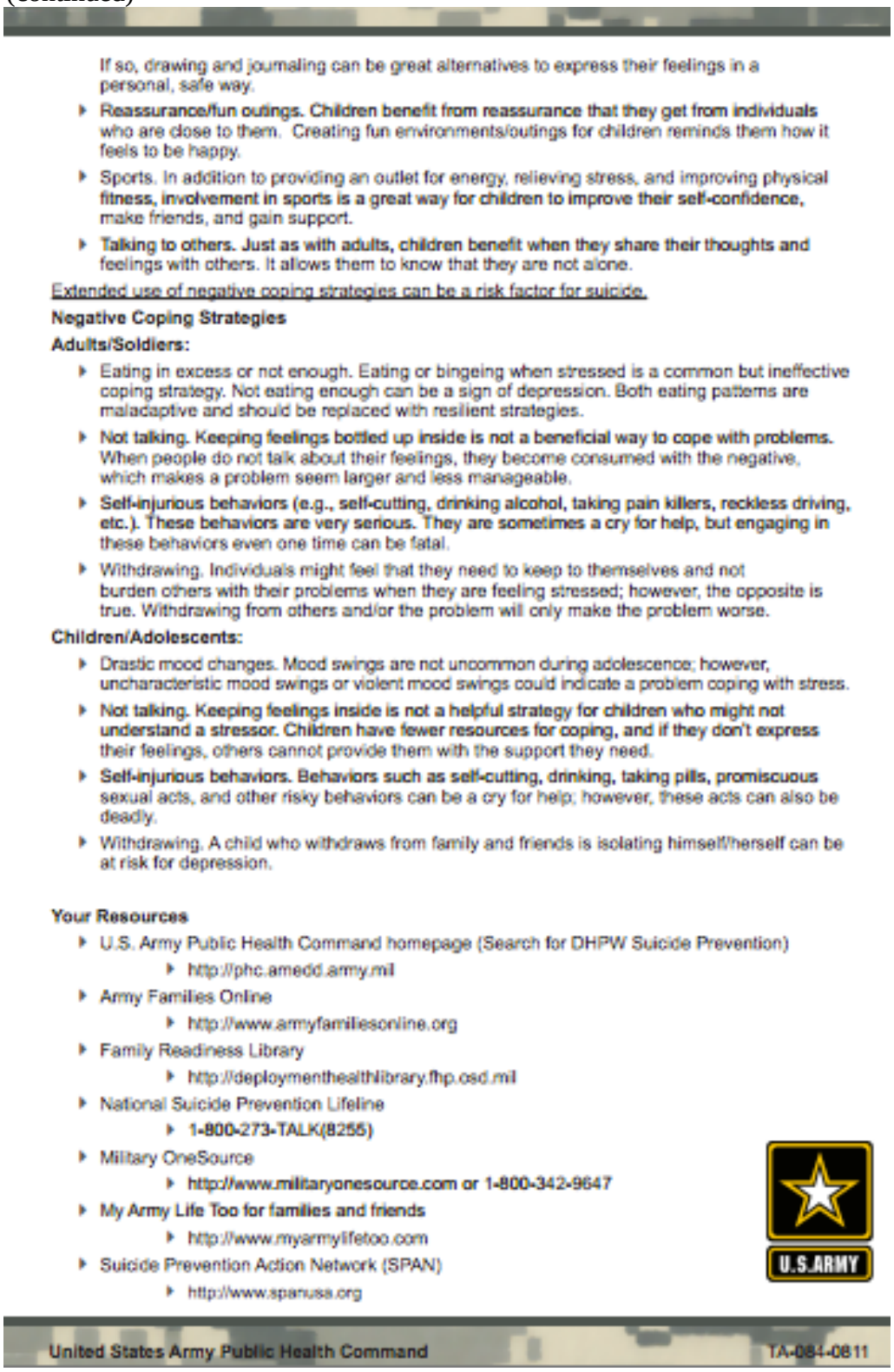
- Breathing deeply. Slow, deep breaths give your body more oxygen and can produce a calming and focused effect.
- Church/religious activities. Attending church or other religious activities can provide support.
- **Cooking. Some find great joy in preparing food. The rhythmic motion of chopping vegetables** or the aroma of freshly baked bread can be very soothing.
- **Exercising. In addition to keeping you fit, exercise can be a great stress reliever and a great coping strategy. When your body is fit and healthy, coping with stressful situations will be** easier.
- **Spending time in nature. Take time to notice the natural beauty around you by taking a walk in a park. Merely getting away from your stresses and finding peace and relaxation, even if only for a few minutes each day, can be beneficial.**
- Support groups. You may feel as if you are the only one dealing with stress and depression; **however, you are not alone. Look for support in your area. These groups can be formal** groups established in the community, informal groups in your neighborhood, or groups associated with the Army via the Army Family Readiness Group (FRG) www.armyfrg.org.
- **Talking to others. Don't underestimate the power of talk. Talking about your thoughts and feelings can be very useful. Even if the person with whom you are talking cannot fix the** problem, the act of putting your emotions into words can be helpful.
- Volunteering. When you give back to others, whether you volunteer to work with children, **the homeless, elderly populations, or at a local animal shelter, you find out just how strong** you are. Visit www.volunteermatch.org for opportunities in your area.
- Writing/journaling. Put your thoughts and emotions on paper. Writing can help you to sort **out how you are feeling. You don't have to show what you have written to anyone. Keeping** a journal can help you track your moods.

Children/Adolescents:

- Church/school activities. Children are social beings. Involving them in church and school activities feeds their need for friendship, provides them with support, and exposes them to **positive influences.**
- **Drawing/journaling. Children can sometimes find it difficult to express their emotions verbally.**

Appendix (continued)

Figure 1 (continued)



If so, drawing and journaling can be great alternatives to express their feelings in a personal, safe way.

- **Reassurance/fun outings. Children benefit from reassurance that they get from individuals** who are close to them. Creating fun environments/outings for children reminds them how it feels to be happy.
- Sports. In addition to providing an outlet for energy, relieving stress, and improving physical **fitness, involvement in sports is a great way for children to improve their self-confidence,** make friends, and gain support.
- **Talking to others. Just as with adults, children benefit when they share their thoughts and** feelings with others. It allows them to know that they are not alone.

Extended use of negative coping strategies can be a risk factor for suicide.

Negative Coping Strategies

Adults/Soldiers:

- Eating in excess or not enough. Eating or bingeing when stressed is a common but ineffective coping strategy. Not eating enough can be a sign of depression. Both eating patterns are maladaptive and should be replaced with resilient strategies.
- **Not talking. Keeping feelings bottled up inside is not a beneficial way to cope with problems.** When people do not talk about their feelings, they become consumed with the negative, which makes a problem seem larger and less manageable.
- **Self-injurious behaviors (e.g., self-cutting, drinking alcohol, taking pain killers, reckless driving, etc.). These behaviors are very serious. They are sometimes a cry for help, but engaging in** these behaviors even one time can be fatal.
- Withdrawing. Individuals might feel that they need to keep to themselves and not burden others with their problems when they are feeling stressed; however, the opposite is true. Withdrawing from others and/or the problem will only make the problem worse.

Children/Adolescents:

- Drastic mood changes. Mood swings are not uncommon during adolescence; however, uncharacteristic mood swings or violent mood swings could indicate a problem coping with stress.
- **Not talking. Keeping feelings inside is not a helpful strategy for children who might not understand a stressor. Children have fewer resources for coping, and if they don't express** their feelings, others cannot provide them with the support they need.
- **Self-injurious behaviors. Behaviors such as self-cutting, drinking, taking pills, promiscuous** sexual acts, and other risky behaviors can be a cry for help; however, these acts can also be deadly.
- Withdrawing. A child who withdraws from family and friends is isolating himself/herself can be at risk for depression.

Your Resources

- U.S. Army Public Health Command homepage (Search for DHPW Suicide Prevention)
  - http://phc.amedd.army.mil
- Army Families Online
  - http://www.armyfamiliesonline.org
- Family Readiness Library
  - http://deploymenthealthlibrary.fhp.osd.mil
- National Suicide Prevention Lifeline
  - **1-800-273-TALK(8255)**
- Military OneSource
  - **http://www.militaryonesource.com or 1-800-342-9647**
- **My Army Life Too for families and friends**
  - http://www.myarmylifetoo.com
- Suicide Prevention Action Network (SPAN)
  - http://www.spanusa.org

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United States Army Public Health Command TA-084-0811

Appendix (continued)

Figure 2
Suicide Prevention: DOD Family ACE Card (USAPHC, 2010)