

AETC PAMPHLET 44-104

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Medical

***A SUICIDE PREVENTION AND
INTERVENTION GUIDE FOR COMMANDERS
AND FIRST SERGEANTS***

**THE AETC
SUICIDE
PREVENTION
PROGRAM**



AETC LINK PROGRAM

Look for possible concerns

Inquire about concerns

Note level of risk

Know referral resources and strategies

A SUICIDE PREVENTION AND INTERVENTION GUIDE FOR COMMANDERS AND FIRST SERGEANTS

This pamphlet, AETCPAM 44-104, implements AFD 44-1, *Medical Operations*.

Suicide was the leading cause of death for AETC enlisted personnel for 1990 to 1993 and the second leading cause of death for 1994. It is said that each suicide intimately affects at least six other people. Suicide is not only a tragic loss of life, but it is disruptive to the surviving members of the military community. It can also have a direct impact on mission sustainability through the loss of the victim, his or her productivity, and the associated disruption caused. Finally, this loss also includes the economic value invested in the victim, the associated death benefits, the loss of anticipated contribution to the mission, and the cost of the victim's replacement.

Suicides can be understood and dealt with, and it is likely a substantial number can be prevented.

The AETC LINK Program was designed as a preventative effort which develops a "web" linking individuals, supervisors, first sergeants, commanders, the community, and medical professionals who create concentric circles of concern. Most suicidal individuals want to live, but many are unable to see alternatives to their problems. They often view their situation as hopeless. We must "link" personnel to helping resources and alternatives once we become aware of the need.

Suicide was the leading cause of death for AETC enlisted personnel from 1990 to 1993 and the second leading cause of death for 1994.

Even though mental health intervention is effective and important in these cases, its major shortcoming lies in the fact that the healthcare system can only act if it is aware of the problem. This places the responsibility on individuals to seek help on their own or be referred by others. Sadly, we have fallen short in this area. Two-thirds of the active duty Air Force suicide victims studied from 1983 to 1993 had not come in contact with the healthcare system. To turn this around, buddy care must flourish with early identification and referral of potentially at-risk personnel by those who perhaps know them best--their friends and coworkers. In addition, supervisory personnel are the initial point of referral in most cases and must act as a gateway to the helping resources for their personnel.



Each of us have a part in the successful implementation of this program. This guide will explain the AETC LINK Program and serve as a ready reference for carrying it out at the squadron level.

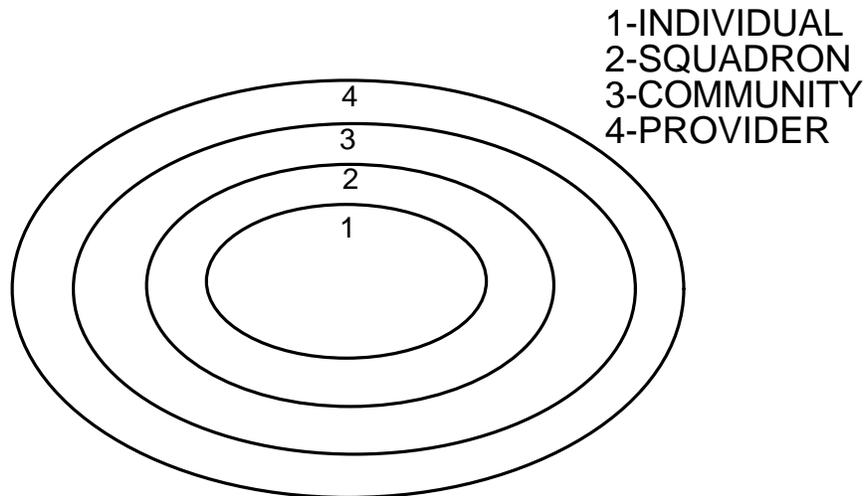
THE LINK INTERVENTION MODEL

A model is a helpful way to depict a program and give a big picture outlook. Understanding the model and how the parts fit together is essential to its effective implementation. The model is essentially like a spider web. A spider web interlocks one strand with the next, in effect

creating concentric circles. No matter where it is touched, its movement signals corresponding action by the spider.

The model should do the same. It surrounds the base community in linked circles of concern which prompt appropriate corresponding actions no matter where one enters the “web.” The total strength of this web is based on the contribution of the individual strands. Commanders and first sergeants are critical to this process in their role as squadron gatekeepers. As the model depicts, there are four levels of intervention, each with different intervention strategies.

CONCENTRIC INTERVENTION MODEL



LEVEL 1--INDIVIDUAL

The primary theme of level 1 is *buddy care*. Awareness training with emphasis on stress and suicide risk factors will be conducted for all personnel. This training is conducted at the first duty station and all levels of PME. Other personnel

are trained through squadron-specific awareness training conducted in small groups. The purpose of the training is to encourage the early identification and referral of potentially at-risk individuals to supervisory personnel in level 2.

LEVEL 2--SQUADRON GATEKEEPERS

The primary themes of level 2 are *triage* and *mentoring*. Specific initial and annual refresher training is conducted for commanders and first sergeants in the identification and referral of at-risk personnel, squadron-level risk management programs, and managing organizational stress. Training is conducted at least annually for all supervisory personnel in the identification and referral of potentially at-risk personnel.

Once these at-risk individuals are identified, they can be referred to the appropriate helping resources. The purpose of this training is to equip squadron supervisory personnel with the tools necessary to act as gatekeepers, lowering barriers to self-referral and destigmatizing help-seeking behavior through changing the corporate culture. Mentoring at the supervisory level will assist in this effort and is a natural complement to the “buddy care” concept encouraged at the individual level. Referrals should be made to community resources within level 3, such as family support center or chaplains, or directly to level 4, mental health, as in the case of emergency referrals of at-risk personnel.

LEVEL 3--COMMUNITY GATEKEEPERS

The primary theme of level 3 is *network*. A base helping-professions team is established to network and coordinate service delivery. This team is also trained in the identification and referral of potentially at-risk personnel. A base-level critical incident response team formed from these individuals will also assist personnel in event the event of a natural disaster, major accident, suicide, or other potentially traumatic event. A Behavioral Health Survey is being developed to assess the organizational culture and target squadron-specific risk factors. The results of this squadron-level assessment are reported to squadron commanders to assist with the development of squadron-specific intervention strategies. The base Health Promotions Working Group monitors nonsquadron-specific aggregate results for base stress climate assessment purposes.

LEVEL 4--MEDICAL PROFESSIONALS

The primary theme of level 4 is *to provide care*. All applicable medical providers are also trained in the identification and referral of at-risk personnel. Mental health personnel make regular field visits to squadrons so prevention activities such a stress management can be delivered in the organization. Mental health personnel provide consultation services to the commander in the area of managing organizational behavior and stress. Also, squadron-specific awareness training discussed previously in level 1 is conducted during these field visits.

KNOW THE FACTS

1. Suicides can be prevented. Most suicidal persons want to live; they are just unable to see alternatives to their problems. They often view their situation as HOPELESS.
2. Most often, suicidal persons are temporarily overwhelmed with real LIFE EVENTS. Some of the most commonly experienced are relationship difficulties, separation, divorce, financial problems, pending legal or administrative actions, investigation, work problems, loss of a loved one, major illness, etc.
3. Most suicidal persons give definite WARNINGS of their suicidal intentions, but we are often unaware of the significance of these or do not know how to respond.
4. Suicide cuts across all ranks, ages, and economic, social, religious, and ethnic boundaries.
5. Suicide is the eighth leading cause of death in the US and the third leading cause among 15- to 24-year-olds, behind accidents and homicide.
6. Males commit suicide at rates and numbers three to four times that of females.

Most suicidal persons give definite WARNINGS of their suicidal intentions.

7. Although there are no official US statistics on suicide attempts, it is estimated there are at least 8 to 20 attempts for each death by suicide.

8. Females have been generally found to make three to four times as many attempts as males.

9. Feelings of HOPELESSNESS, such as “there are no solutions to my problem,” are found to be more predictive of suicide than a diagnosis of depression per se.

10. The SOCIALLY ISOLATED are generally found to be at high risk for suicide.

11. It is estimated that suicide intimately affects at least six other people.

12. Persons with a mental health diagnosis are generally associated with higher risk of suicide. Groups at particular risk are the depressed, schizophrenics, alcoholics, and those with a panic disorder.

13. Currently, there are over 30,000 suicides annually nationwide (83 per day, one every 17 minutes), with more than 12 of every 100,000 Americans killing themselves.

14. Firearms are currently the most utilized method of suicide.

15. Suicide ranked as the leading cause of death from 1990 to 1993 among enlisted members in AETC and the second leading cause in 1994.

BE AWARE OF THE WARNING SIGNS

There is no typical suicidal victim, but there are some common warning signs. When acted upon, a life can be saved. A suicidal person may:

- Talk about committing suicide
- Have trouble eating or sleeping
- Experience drastic changes in behavior
- Withdraw from friends or social activities
- Lose interest in hobbies, work, school, etc.

- Prepare for death by making final arrangements
- Give away prized possessions
- Have attempted suicide before
- Take unnecessary risks
- Have had a recent or severe loss
- Be preoccupied with death and dying
- Lose interest in his or her personal appearance
- Increase his or her use of alcohol or drugs

BE AWARE OF FEELINGS

Many persons have had thoughts about suicide at some point in their lives. Most decide to live because they come to realize the crisis is temporary and death isn't. On the other hand, people having a crisis often think their situation is inescapable and feel a sense of hopelessness and loss of control. Some commonly experienced feelings are:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat, or work
- Can't get out of depression
- Can't make sadness go away
- Can't see a future without pain
- Can't see themselves as worthwhile
- Can't seem to get someone's attention
- Can't seem to get control

BE AWARE OF DOS AND DON'TS

- Be aware. Learn the warnings signs.
- Get involved. Become available. Show interest and support.
- Ask if they are thinking about suicide.

- Be direct. Talk openly about their suicidal thoughts. Determine if they have a plan.
- Question accessibility to guns, pills, etc.
- Listen. Allow expression of feelings.
- Don't lecture or debate. Try to be nonjudgmental.
- Don't dare them to do it.
- Don't give advice.
- Don't put them off. Take all threats seriously.
- Offer empathy, not sympathy.
- Don't act shocked. This will put distance between them and you.
- Don't be sworn to secrecy. Seek support.
- Offer hope that alternatives are available. Take action. Remove means, if possible.
- Don't leave them alone. Get help immediately.

WHAT TO DO--LONG-TERM

PROMOTE unit-wide sensitivity to potential risk factors. Unit members should be encouraged to talk to their supervisors, first sergeants, or commanders without fear of retribution when they feel the need.

BE ALERT to factors that may cause stress in your subordinates. Take care of your people.

KNOW your people. Be aware of changes in their attitude, behaviors, and (or) performance.

IDENTIFY "at-risk" personnel. Be on the lookout for individuals who appear to have problems and get help for them. Don't place those who are at risk in demanding situations or where they cannot be observed.

BE CONCERNED about the welfare and morale of your people. If you are aware of personnel experiencing significant life events, show an interest and ask how they are doing frequently and regularly. Don't underestimate the significance of these events.

COMMUNICATE with your people. STOP moralizing and providing easy solutions. LOOK for nonverbal cues and inconsistency between what is said and what is done. LISTEN for the feelings behind the words--feelings of despair and hopelessness should prompt immediate concern.

BE AVAILABLE AND SUPPORTIVE. Manage by walking around to get "eyes on" your people and their situation and to allow them access to you. Act to get help or services for your people and have their supervisor go with them if necessary.

WHAT TO DO--IMMEDIATELY!

If you are concerned about an individual you feel may be at risk, get help immediately. Don't leave the person alone. Be up front with them; communicate your concerns and what you are doing to get them help. Contact a mental health provider and discuss the situation. If it is determined they need an immediate emergency referral to mental health, have their immediate supervisor go with them. Besides helping the provider understand the situations and (or) behaviors which prompted the referral, it sends a powerful message to your people that you care for them and have a vested interest in their well-being.

If you encounter a suicide in progress, get help immediately through the hospital emergency room or call 911. Remain calm and stay with the individual until help arrives. If the individual has a dangerous weapon or firearm, don't be a hero. Remember, the suicidal person is emotionally out of control and in these situations your life may also be in danger.

CLUSTERING

One risk factor that has emerged from research on suicide is the suicide "contagion" or cluster effect. This is a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide.

Although this concept is not easily understood, it appears that any given community has a population “at risk” consisting of people who are

One risk factor that has emerged from research on suicide is the suicide “contagion” or cluster effect. This is a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide.

more than a casual risk for suicide. Most of these people are perhaps ambivalent about taking their lives. They may think about suicide frequently, but have not committed to a plan to act. However, if another individual does commit suicide, especially if he or she is viewed as someone like himself and herself, this reinforces the idea that suicide is an option. Research has indicated that the effect of contagion appears to be strongest among younger age groups. If this is true, it is a powerful incentive to be especially mindful of the need for preventive intervention in the wake

of a completed suicide. The following suggestions should be considered:

- Inform other unit members of the basic circumstances of the suicide.
- Don’t talk directly about the act. Too much detail may serve as a “how to” description.
- Seek the assistance of chaplains and other helping professionals, especially immediately following your initial formal discussion of the event with unit personnel. These professionals should be on scene during this initial period. The object is to afford personnel the chance to ventilate any feelings they might have surrounding this death. It also gives the helping professionals a chance to get an “eyes on” look at individuals who may be more deeply disturbed.
- Conduct personal interviews with members of the unit who you feel may be most seriously affected

by this event. If it appears they are having difficulty with this event, bring them to the attention of the chaplain or mental health professional.

- Don’t glorify the suicide victim’s positive characteristics. If his or her *problems* are not acknowledged in the presence of laudatory statements, suicidal behavior may appear attractive to others at risk, especially those who rarely receive positive reinforcement for desirable behaviors.
- Be aware that some characteristics of news coverage of suicide may contribute to the contagion. All parties should understand that a scientific basis exists for concern that news coverage of a suicide may contribute to the cause of other suicides.
- Don’t present simplistic explanations. The final precipitating event is rarely the only cause and shouldn’t be seen as a tool for accomplishing certain ends. The majority of victims had multiple factors that contributed to their situation. Just acknowledging this without significant detail is helpful.
- Don’t engage in repetitive, ongoing discussions of the suicide.

RISK MANAGEMENT

As mentioned previously, no one is immune to being potentially at risk for suicide. There is no typical victim, but we do know victims have experienced life events which they interpreted as being overwhelming or hopeless. Two tools to assist you in your risk management efforts are attached--a Military Life Survey (attachment 1) and an Awareness Profile (attachment 2).

Military Life Survey. This tool should be used to think about potential life event stressors your people might be experiencing. This survey can be duplicated and distributed to all personnel to assist in stress management activities. This can be done at specified intervals, such as quarterly or semiannually.

The point values are only crude indicators for possible concern and should be followed up with personal engagement with people you are concerned about to determine how they are handling these events. Air Force members scoring under 200 points are more **LIKELY** to be experiencing good physical and emotional health. Those scoring between 200 and 400 points on this scale should consider enrollment in a stress management program, but are not **LIKELY** to represent a danger to themselves or others. Air Force members scoring more than 400 points should be **STRONGLY** encouraged to seek counseling services or at least enter a formal stress management program as soon as possible. Some of these individuals may be at significant risk for accidental or purposeful self-harm.

The survey was developed by Lt Col (Dr) Harry Howitt, 12th Medical Group, Randolph AFB TX. It was adapted from a similar study published in 1968 by Thomas H. Holmes and Richard H. Rahe in the *Journal of Psychosomatic Research*.

Awareness Profile. This device is an awareness tool. It should be used anytime you become concerned about one of your personnel and his or her potential level of risk. It is recommended that this tool be limited to use by the commander or first sergeant. It is only intended as a device to help you assess potential areas of risk for personnel who are identified to you as a possible concern. Individuals with only a couple of factors should increase your concern level. Supervisors should be more directly involved with these individuals to demonstrate concern through providing assistance, support, and encouragement.

Individuals who seem to be experiencing multiple factors should be brought to the attention of the commander by a face-to-face interaction with the first sergeant if the commander is not already aware of the situation. This discussion should include a review of known concerns and what you could do or are doing to assist the individual. Consultation with a mental health provider may be indicated to determine further action.

The profile was developed by Lt Col (Dr) Harry Howitt of the 12th Medical Group and Maj Richard Handley of HQ AETC/SG, Randolph AFB

TX. It is based on categories of risk and frequency of occurrence data identified in the AFOSI study *Active Duty Suicides, 1983-1993*, authored by Dr Charles McDowell. It is not meant to be a substitute for personal engagement with individuals who concern you or for using good judgement in determining risk and courses of action to be taken in response to this determination.

If you feel you need more definitive guidance, HQ AETC/SGPCM has a version with weighted values by each factor including a decision matrix at the bottom based on the total scores. This version may be obtained from HQ AETC/SGPCM at DSN 487-5748.

NOTE: Individuals who make direct suicidal remarks or are judged to be an imminent risk should be referred to Mental Health immediately. Do not leave them alone. Have the supervisor escort them to this appointment.

CONCERNS

How do you talk to someone about your concerns? Again, this is not an exact science, but the following could serve as an outline:

EVENT. Discuss the events you are aware of that concern you and listen for other potential events you are unaware of. For example, "I heard about the loss of your mother and was concerned. How are you doing with this?"

INTERPRETATION AND MEANING. No two individuals interpret events the same way. Events interpreted as being hopeless are often indicative of potential risk. An inquiry should be made to determine how individuals are interpreting these events and the meanings these events have to them.

THOUGHTS. Frequently, based on their interpretation, individuals have thought about potential actions based on these meanings or beliefs about their situation. Again, asking what they have thought about as a result should be pursued.

FEELINGS. Many behaviors are preceded by a feeling or emotion, particularly suicide. Again,

following this line of conversation, inquire how they have been feeling as a result.

PLAN. Determine how they plan to handle this situation. If individuals indicate potential suicidal thoughts, the question needs to be asked very clearly, “Have you thought about suicide? Do you

have a plan?” Determine also the accessibility to means. Again, if there is any doubt, consult with a mental health provider. If it is after duty hours, contact appropriate helping resources--the hospital emergency room, 911, Security Police, etc. DO NOT LEAVE THE PERSON ALONE.

WALTER A. DIVERS, JR., Colonel, USAF, MC
Director of Medical Services and Training

Attachments

1. Military Life Survey
2. Awareness Profile

MILITARY LIFE SURVEY

<i>RANK</i>	<i>MILITARY LIFE EVENT</i>	<i>VALUE</i>
1	Death of Spouse	100
2	Divorce.....	73
3	Marital Separation or Remote Tour.....	65
4	Suicide of a Family Member or Close Friend.....	63
5	Death of a Close Family Member.....	63
6	Personal Injury or Illness	53
7	Marriage.....	50
8	Reduction in Rank	47
9	Marital Reconciliation or Reunion From Long Tour or TDY	45
10	Retirement, Separation, or PCS (Desired or Not).....	45
11	Change in Family Member's Health.....	44
12	Pregnancy (Desired or Not)	40
13	Significant Emotional Distress, such as Depression, Anxiety, Anger, etc.....	39
14	Addition to Family	39
15	Frequent TDYs	39
16	Change in Financial Status	38
17	Death of a Close Friend	37
18	Voluntary or Involuntary Cross-Training	36
19	Change in Number of Marital Arguments	35
20	Mortgage or Loan Over \$50,000	31
21	Harsh Air Force Disciplinary Action.....	30
22	Change in Work Responsibilities	29
23	Son or Daughter Leaving Home	29
24	Trouble with In-Laws	29
25	Outstanding Personal or Military Achievement	28
26	Spouse Begins or Stops Work	26
27	Starting or Ending Civilian or Military School	26
28	Change in Living Conditions.....	25
29	Revision of Personal Habits, such as Smoking or Drinking.....	24
30	Trouble With Chain of Command	23
31	Change in Work Hours or Conditions	20
32	Change in Local Residence.....	20
33	Change in Schools, Self or Family Member.....	20
34	Change in Recreational Habits	19
35	Change in Church Activities.....	19
36	Change in Social Activities	18
37	Mortgage or Loan Under \$50,000	17
38	Change in Sleeping Habits or Quality	16
39	Trouble With Air Force or Civilian Coworkers	15
40	Change in Eating Habits, Gained or Lost Weight	15
41	Annual Leave.....	13
42	Religious Holiday Season.....	12
43	Minor Air Force Disciplinary Action	11
	TOTAL _____	

Attachment 2

AWARENESS PROFILE

DEMOGRAPHIC FACTORS

AGE: 22 - 30 _____

GRADE: Enlisted (E-3 - E-6) _____
Officers (O-2 - O-4) _____

RISK FACTORS

RELATIONSHIP: Problems With Intimate Relationships _____
(Marital problems, seperation, divorce, breakups)

HISTORY: Prior Gestures, Attempts, or Allusions _____
(Vague allusions/threats or indirect comments) *see note

EMOTIONAL: Changes in Mood/Emotional status _____
(Depressed, sad, apathetic, hopeless, irritable, anxious, etc.)

WORK: Work-Related Problems _____
(Academic problems for tech tng students)

SUBSTANCE : Substance Abuse Problems _____

FINANCIAL: Financial Problems _____

LEGAL: Legal Problems/Investigation _____

TREATMENT: Mental Health/Family Advocacy _____

DEATH: Recent or Unresolved Loss of Loved One _____

HEALTH: Changes in Physical Health _____

*** NOTE: Personnel making direct suicidal remarks or judged to be an imminent risk should be referred to mental health immediately!**

BRIEF EXAMPLE: A 27-year-old white male, active duty Air Force staff sergeant filled out a Military Life Survey during squadron screening. His

survey was filled out with the following life events noted:

<i>Rank</i>	<i>Military Life Event</i>	<i>Value</i>
2	Divorce.....	73
3	Remote Tour (Upcoming).....	65
5	Death of a Close Family Member.....	63
13	Significant Emotional Distress.....	39
16	Change in Financial Status.....	38
28	Change in Living Conditions.....	25
32	Change in Local Residence.....	20
33	Change in Self.....	20
36	Change in Social Activities.....	18
37	Mortgage or Loan Less Than \$50,000.....	17
38	Change in Sleeping Habits or Quality.....	16
40	Change in Eating Habits.....	15
	TOTAL	409

Due to the person’s score, the first sergeant personally engaged him or her to determine how he was handling these life events, following the previously recommended approach (Event--Meaning--Thoughts--Feelings--Plan):

FIRST SERGEANT: “John, I heard about your recent divorce. How are you handling it?”

JOHN: “Not good, especially due to the financial hardships it has created and the fact that I don’t get to see my kids like I used to. I guess since my dad died last month, I don’t really have anyone to talk to. This upcoming remote certainly isn’t going to help. I feel so tired, I don’t sleep or eat much anymore. I don’t feel like this will ever end.”

FIRST SERGEANT: “I’m really concerned about you. You mentioned some very significant losses. What do these mean to you?”

JOHN: “I don’t see any future for myself. It seems hopeless with all that’s on me right now.”

FIRST SERGEANT: “You mentioned feeling hopeless and no sense of future. What have you been thinking about lately?”

JOHN: “Actually, all I think about is how unfair life is. What did I do to deserve this?”

FIRST SERGEANT: “How do you feel inside right now?”

JOHN: “I feel sad, depressed; numb, in fact. I don’t know if I have any more feelings at all.”

FIRST SERGEANT: “What have you thought about doing to deal with all this?”

JOHN: “I feel like ending it all. I would just like to go to sleep and never wake up.”

FIRST SERGEANT: “Do you feel like killing yourself?”

JOHN: “Yes. In fact, that’s all I think about.”

FIRST SERGEANT: “Do you have a plan?”

JOHN: “I bought a gun yesterday. I thought about driving up to the lake, getting by myself, and then doing it.”

FIRST SERGEANT: “John, I don’t want you to do that. I am concerned and want to help. I want us to talk to the commander about this. I am sure she

would be concerned too. I feel there are some things we can do to help. Will you go with me?"

JOHN: "Yea, I guess. I just don't know what else to do."

Besides the direct communication of a suicidal intent from this individual, we can also see that he is at risk on the basis of the life events he shared during this conversation being applied to the Awareness Profile.

RISK FACTOR

Age	<u>x</u>
Grade	<u>x</u>
Relationship Problem (spouse)	<u>x</u>
Financial Problems	<u>x</u>
Death (father)	<u>x</u>
Health (fatigue, sleep, appetite problems)	<u>x</u>
Emotional (depression)	<u>x</u>

Due to his verbalized suicidal intent, he should be referred to mental health immediately

Because of this elevated level of suicide victimization, the category of enlisted white males is commonly referred to as the Air Force's high risk population.

after the consultation with the commander. If he had not made a direct suicidal threat, on the basis of the Awareness Profile score, mental health should be consulted for possible referral.

CAUTION: Since individuals process life events differently, we cannot underestimate the

significance of a single life event, such as a divorce, investigation, or disciplinary action, combining with other factors already present. We need to talk to these individuals as well as assess how they are coping with their situation. If there are any doubts as to their level of risk, contact a mental health

provider. IF A SUICIDAL THREAT IS VERBALIZED, REFER TO MENTAL HEALTH.

RISK CATEGORIES BASED ON AIR FORCE SUICIDES, 1983 - 1993

Data from the OSI study of active duty suicides from 1983 - 1993 by Dr. Charles McDowell, provides useful insight into developing an understanding of the demographics of potentially at-risk personnel. We must exercise caution in assuming that these totally represent those possibly at risk. As stated previously, anyone can be at risk. However, we do know that past suicides have been preceded by life events that were common to many of the victims.

In the years from 1983 to 1993, the Air Force averaged 66 suicides yearly, which means an active duty suicide occurred about once every 5 days. Over this time period, the overall average suicide rate was 11.8 per 100,000 active duty Air Force members compared to 12.2 per 100,000 for the total US population. It must be noted these are gross rates which have not been adjusted for age, sex, or race and there are significant variations within the larger population which make gross rates themselves inadequate as an accurate measure of the problem. For instance, among active duty enlisted members of AETC, suicide ranked as the leading cause of death from 1990-1993 with an average rate per 19.49 per 100,000. It was the second leading cause of death for 1994 with a rate of 16.87 per 100,000.

The average age for the Air Force suicide victim was 29, with about 88 percent of the suicides committed by whites, 10 percents by blacks, and 2 percent by other races. OSI data indicates that 89 percent of the total victims were enlisted, with enlisted white males representing 74 percent of this group. Because of this elevated level of suicide victimization, the category of enlisted white males is commonly referred to as the Air Force's *high risk population*. Males accounted for approximately 94 percent of all suicides during this time period. However, current AETC data suggest that females attempt suicide at rates greater than that of males.

For completers of suicide within AETC, a gun has been the most common method. From our data on attempters, overdose was the most common method. The majority of attempted as well as completed suicides within AETC for 1994 occurred on base.

Relationship Difficulties

OSI data indicates that fully 76 percent of the victims of suicide from 1983 - 1993 experienced serious problems in intimate relationships.

Multiple Problems

Slightly over 60 percent of the victims in this study experienced multiple, serious problems at the time of their death.

Work-Related Problems

Not surprisingly, 43 percent of the victims had work-related problems. Of those who were married, more than a third had both serious marital and work-related problems. Individuals with histories of unsatisfactory work performance should be of concern, as well as those with histories of difficulty with coworkers. A failure to successfully assimilate one's self into the organizational culture, more specifically with one's coworkers, seems to also be related to potential risk in this area. We know from experience with combat units that group cohesiveness is probably one of the most potent buffers against combat stress. Individuals who are not integrated into the unit, newcomers, and those who socially isolate themselves are not as likely to be afforded the positive benefits of this group support, and hence could be at greater risk. The old saying, "No man is an island," indicates the need we all have for significant others in our lives, especially during times of difficulty.

Substance Abuse

At least one third of the victims had been involved with either alcohol (22 percent) or drug abuse (10 percent). Substance abuse cannot be adequately viewed in isolation as a cause, but should be more appropriately thought of as a symptom. For many, it is a form of self-medication, a way to cope with their problems, or an escape.

Financial Problems

Financial problems were a factor in 23 percent of the suicide victims. Individuals you already know of, as well as those you might potentially refer for financial assistance, should be of concern. They may have other problems which will not be known to you without some further discussion and attention to their situation.

Mental Health Problems

Approximately 23 percent of the victims were under, or had recently been under, mental health care at the time of their death. At least 53 percent of the victims gave a clear indication they were depressed at the time of their death, and 13 percent had made a previous suicide attempt or gesture.

Legal Problems

OSI data indicated that 16 percent of the victims were involved in difficulties with law enforcement agencies or the courts at their time of death. About half of these were under OSI investigation.

Being under investigation for a suspected criminal offense, especially if the crime involves moral turpitude, is extremely stressful. This is compounded by the fact that legal outcomes are difficult to anticipate, and many suspects facing serious legal problems worry about public disgrace and a very real threat to their careers. These individuals should be afforded access to a helping professional for support and should certainly be an object of your attention for potential risk. An especially vulnerable time for these individuals seems to be once they have been initially notified of the investigation, interviewed, and released. It is advisable that you get an "eyes on" these individuals and assess them for potential risk before they are released. Again, if there are any doubts as to the level of risk, contact a mental health provider.

Other individuals who should be of concern for review are any individuals currently with UIF's and those with derogatory information in their PIFs.

Death-Related Issues

About 5 percent of the suicides involved a death-related issue, almost always involving the death of someone close to the victim.

... few will change until the system requires that they do so. If we are angry at our subordinates' continual lack of responsibility, yet we continue to compensate and take responsibility for them, why should they change?

way they act--their behavior. Oddly enough, in many of these situations, they only do what the system allows them to do or what they feel it expects of them. Given this scenario, few will change until the system requires that they do so. If we are angry at our subordinates' continual lack of responsibility, yet we continue to compensate and take responsibility for them, why should they change?

Applied to an organizational perspective, employees often act in a manner consistent with what they feel their boss expects. As part of the AETC LINK Program, we talk of "changing the organizational culture" at the squadron level as a means of destigmatizing and encouraging help-seeking behavior and building a network that supports the early identification and referral of potentially at-risk personnel. As a part of that, we must make sure the system itself is not part of the problem, but contributes to positive organizational behavior. This must begin with leadership. How much difference can leadership really make? The next section will address this.

Health Problems

Health problems were a factor in 4 percent of the decisions to commit suicide.

MANAGING ORGANIZATIONAL BEHAVIOR

There is an old adage among systems theorists which says, "The system creates its own behavior." Many times, we are angry at our subordinates or our children because of the

CONCEPT OF PYGMALION

Pygmalion was a sculptor in Greek mythology who carved a statue of a beautiful woman who subsequently came to life. The notion that one person can transform another, or a manager can transform an entire organization, was the basis for a "classic" article that appeared in the *Harvard Business Review* by J. Sterling Livingston on the application of Pygmalion in management. Similarly, Robert Merton's classic 1957 book, Social Theory and Social Structure, discussed the concept of the "self-fulfilling prophecy" and the effect of expectations, or prophecy, on outcome.

The influence of self-fulfilling prophecies and the Pygmalion effect are applicable to the field of organizational behavior, and management researchers and practitioners are slowly realizing the influence of expectations on behavior. Therefore, every manager should understand how the Pygmalion effect works.

In George Bernard Shaw's *Pygmalion*, Eliza Doolittle explains, "The difference between a lady and a flower girl is not how she behaves, but how she is treated." Some managers treat their subordinates in a way that leads to superior performance, but many unintentionally treat their subordinates in a way that leads to lower performance than they are capable of achieving. Research in this area has revealed:

- What managers expect from their subordinates and the way they treat them largely determines their subordinates' performance and progress. Said another way, as keepers of the system, managers have a powerful effect on creating the behavior of their subordinates.
- A unique characteristic of superior managers is the ability to create high-performance expectations that subordinates fulfill.
- Less effective managers fail to develop similar expectations and, as a consequence, the productivity of subordinates suffers.

- More often than not, subordinates appear to do what they believe they are expected to do.

The way managers treat, not organize, subordinates is the key to high expectations and productivity.

- Unsuccessful personnel have great difficulty maintaining their self-image and self-esteem. In response to low expectations from their supervisors, they typically attempt to avoid further damage to their egos by avoiding situations which might lead to greater failure. Low expectations, when combined with

damaged egos and low self-esteem, lead personnel to behave in a manner that increases the probability for failure, thereby becoming a self-fulfilling prophecy and fulfilling their supervisor's expectations.

KEYS TO USING THE POWER OF EXPECTATIONS

Perhaps **our greatest organizational challenge** is to prevent the underdevelopment, underutilization, and ineffective management and utilization of our most valuable resource--our people, especially our younger, developing talent.

A key trait of effective leaders is their own positive self-regard, which seems to exert its force by creating in others a sense of confidence and high expectations. For leaders to be a Pygmalion, they must acquire knowledge and skills necessary to be confident of their high expectations and make them credible to their employees.

Some recent research on leadership failures has indicated credibility is lost after two to three failures known to subordinates. Nothing succeeds like success.

Supervisors can't avoid the depressing cycle of events which flow from low expectations merely by hiding or masking their feelings because the message is usually communicated unintentionally, without conscious action on their part. Managers

often communicate most when they think they are communicating the least.

Critical to the communication of expectations is not so much what managers say, but what they do. The silent treatment, or indifferent and noncommittal treatment, more often than not communicates low expectations and leads to poor performance.

Managers are often more effective in clearly communicating low expectations than high ones, even though they believe the opposite. Positive feelings usually do not come through clearly enough.

Superior managers seem to have greater confidence in their own ability to select, train, and motivate their subordinates, and they don't easily give up on themselves or their subordinates.

The way managers treat, not organize, subordinates is the key to high expectations and productivity.

Subordinates will not strive for high levels of productivity unless they feel the boss' high expectations are realistic and achievable. In fact, research has indicated that the relationship of motivation to expectancy of success varies in the form of a bell-shaped curve. The degree of motivation and effort rises until their expectancy of success reaches 50 percent, then begins to fall even though the expectancy of success continues to increase. No motivation or response is aroused when the goal is perceived as virtually certain or virtually impossible to attain. Secondly, if subordinates failed to reach performance expectations that are close to their own level of aspirations, they will lower personal performance goals and standards, leading to decreased performance and development of negative attitudes.

Managerial expectations have their strongest influence on younger personnel because, as personnel mature and gain experience, they tend to see themselves as their career record (or the reality of their past performance) implies.

The first year is a critical period for learning and a time when the new trainee is uniquely ready to develop or change in the direction of corporate expectations. This leads to the internalization of positive job attitudes and high standards, and these lead to and are reinforced by strong performance and behavior in later years.

A new trainee's first boss is likely to be the most influential in his or her career. If these supervisors are unable or unwilling to develop the skills younger personnel need to perform effectively, they will set lower standards than these personnel are capable of achieving. Since these trainees feel their abilities are not being developed or used, this can lead to impaired self-image, lackluster performance, and negative attitudes toward their job and possibly their own career in the Air Force.

With few exceptions, the first-line supervisors these personnel are paired with are often the least experienced and at times the least effective in the organization. If our initial corporate expectations for performance mold subsequent expectations and behavior, the initial supervisors of new personnel must be the best we have. These supervisors or managers must be willing and able to facilitate the training, education, and development of these individuals.

Rosenthal and Jacobson (1968) in their book, Pygmalion in the Classroom, identified four factors which positively influence the results of followers:

1. Successful leaders are able to promote the development of a warm, supportive, and accepting climate.
2. Leaders stimulate high performance by frequent and specific feedback which focuses on what the follower is doing right. The goal of this feedback is to help the follower develop more competence and self-confidence.
3. Successful leaders provide all the necessary resources to enhance the skills of the followers and allow them to effectively complete tasks.

4. Leaders should support the attempts by followers by promoting innovative and creative approaches, accepting mistakes during experimentation, and providing assistance in problem-solving.

The importance of managerial expectations permeate the entire military organizational life cycle, beginning with recruitment, during basic training, and continuing until the relationship is terminated through separation or retirement. This impact is **never** more critical than during the training, education, and development process our members undergo.

Organizational leaders must understand and acknowledge the impact of their expectations on the behavior and performance of organizational members and the organizational environment or system these expectations create. Or, as Eliza Doolittle might say, *"The only difference between a high performing organization and a low performing organization is not in the behavior of the members, but how they are treated."*

CONCLUSION--IMPLEMENTING "LINK" IN YOUR ORGANIZATION

LEVEL 1 - Individual, nonsupervisory personnel are trained by mental health personnel in risk-factor awareness and buddy care as new base arrivals. All individuals are trained for their appropriate level at each PME opportunity. The rest of your nonsupervisory personnel will be trained in squadron-specific training opportunities which should be scheduled through Mental Health at least on an annual basis.

LEVEL 2 - Supervisory personnel receive annual squadron-specific training on risk-factor awareness and mentoring. Again, these should be scheduled through mental health. Commanders and first sergeants receive an annual base-level training on risk-factor awareness, referral procedures, and managing organizational behavior. Also, mental health personnel can administer the Behavioral Health Survey to your organization. These surveys are sent to the contractor for processing, and a squadron-specific CEO report is given to you by

mental health personnel detailing your specific organizational profile. This report will indicate potential areas of concern and give organizational-specific prevention prescriptions based on survey results to be used by mental health personnel and other helping professionals.

LEVEL 3 - Level 3 calls for the networking of all the base helping professionals to coordinate service delivery. Nonorganizational specific aggregate results from the Behavioral Health Survey are monitored by the Health Promotions Working Group for base-level climate assessment purposes. A critical incident response team is formed by base helping professionals to respond to the needs of your personnel in the event of a critical incident, such as a natural disaster, major accident, or suicide. If you have a critical incident occur within your organization, the services of this team should be requested immediately.

LEVEL 4 - Level 4 calls for a field delivery model for prevention services from mental health

personnel to your organization. In addition to conducting the required training of individual and supervisory personnel, conducting the Behavioral Health Survey, and carrying out associated prevention prescriptions, mental health personnel arrange for other prevention services such as stress management to be delivered at the unit level. These regular field visits are intended to give helping professionals direct eyes on your personnel and their work environment, and they also allow personnel to consult with helping professionals in a less threatening and more positive manner.

From past experience in this area, we know that many times personnel just need information, but are afraid or don't know who to ask. This gives them the opportunity, as well as gives your supervisory or management personnel the opportunity to consult with helping professionals about specific personnel or organizational issues. Finally, in the event personnel do seek mental health services, having familiarity with the provider makes it a much less threatening experience.