Psychological Autopsy Study of Suicides among United States Special Operations Forces

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Background

The psychological autopsy is a method to systematically and retrospectively collect psychological and related data about the decedent through interviews with people who have personal knowledge and analyses of archived documents and records of the decedent's life. This report discusses aggregate findings from 29 psychological autopsies of Special Operations Forces (SOF) members who died by suicide between January 1, 2012 and December 31, 2015. Both distal (lifetime) and proximal (near-term or acute) risk factors discerned from these autopsies should allow a better understanding of why these decedents were vulnerable to dying by suicide, what compelled them to take their lives at the time of their suicides, and what was observable to others that might inform early detection of impending risk.

Methodology

To collect data about suicide by SOF members, project researchers confirmed the determination of suicide as the cause of death from United States Special Operations Command (USSOCOM) records, identified and contacted next of kin of decedents, and met with next of kin to conduct the psychological autopsy interviews. The psychological autopsy interview involved a semi-structured protocol adapted specifically for this study. Interviews were held with 81 next of kin and close friends to obtain information about the 29 decedents presented in this report.

Process Measures

Researchers found those consenting to participate were eager to share information and observations about the life experiences of their loved ones. All family members provided authorization to collect protected health information; however, USSOCOM was only able to obtain medical records for 17 of the 29 cases.

Findings

The 29 cases studied have a combination of escalating relationship issues, resulting financial issues, humiliation accompanying legal issues, and lack of access to mental health care. Nearly all cases suffered some form of emotional trauma following the first deployment. Interviewees typically saw changes in the SOF member after the first deployment. The downhill trajectory with compounding relationship issues, financial issues, and legal issues occurs over many years.

Suicide prevention training is seen as a check in the box. It is usually online and does not have a skill-building component. Attitude toward suicidal individuals was mentioned as a barrier to help seeking in nearly all cases. Individuals felt their careers would be negatively impacted and hence, their loved ones did not contact the unit leaders either. When a SOF member's actions lead to disciplinary action, the resulting loss of face and loss of peer support was often seen as the trigger event.

Prevention

There is no prior research on preventing suicides among SOF members in the United States or internationally. Based on this study, interventions that may be successful include improving training, counseling services following deployments, reducing stigma around help seeking, providing support when faced with humiliating situations, and restricting access to lethal means.

Limitations

As this study lacks a comparison group of non-suicides, it cannot get at the key differentiators. We need to compare the SOF members who died by suicide to "controls" or individuals who had the same risk factors and did not attempt suicide. There remains some degree of variability from case to case in the depth of the next of kins' or friends' knowledge, their familiarity with proximal events, and the relative recentness of their observations regarding these decedents.

Conclusion

Suicides by SOF members are statistically rare yet highly tragic events. While there seems to be a downward trend since the peak in SOF suicides in 2012, the rates are still approximately 27% higher among SOF members, when compared with the US military. Suicidal behavior is the end point to a complex pathway involving the coming together of a large number of variables. This includes long-term vulnerability, an absence of organizational protection, individual protective factors overwhelmed by the intensity of the SOF operational environment, and the press of stressful events that challenge the moral and ethical norms of a peacetime environment. Understanding as much as possible about individuals who get trapped on this pathway and who see no way out other than by way of the most accessible and lethal of means to end their psychological pain is essential to developing interventions.

Acknowledgements

Project staff would like to acknowledge the tremendous support received from USSOCOM, and all who have been involved in this phase of the study as we work to reduce the tragic loss of these lives.

This study would not have been possible without funding from USSOCOM, and the oversight and support from many individuals in USSOCOM. The work was performed by the American Association of Suicidology (AAS).

Section 1: Prevalence Report

1. Introduction

Suicide rates among SOF are the highest in the military and are higher than that of the general US population. In 2012, suicide rates among SOF more than doubled from the previous year. In his address to the Senate Armed Services Committee, Admiral William McRaven, then-commander of USSOCOM, expressed his concern about suicide rates among the Special Operations community.

This project attempts to analyze the prevalence of suicide among SOF between 2007 and 2015, understand the factors that increase the risk of suicide among SOF, and identify prevention points that could prevent suicides in the future.

1.1 Background

USSOCOM contracted with the AAS to conduct psychological autopsies on SOF members who died by suicide, in an attempt to better understand the problem and identify systemic recommendations to prevent suicide. As part of the data analysis of the psychological autopsy, AAS conducts a background prevalence analysis to provide a background description of the population from whom the psychological autopsy cases were studied. This section of the report summarizes the prevalence analysis. Results of the psychological autopsies are provided in section II of this report.

Based on USSOCOM records, there were 117 suicides among SOF between 2007 and 2015. This ranged from a peak of 23 suicides in 2012, to a low of six suicides in 2007 and 2010. Since the peak in 2012, the number of suicides among SOF has been trending down, but remains significantly higher than the numbers seen in 2007 and 2010. While the annual numbers may seem small, the rate of suicide among SOF were as high as 39.3 per 100,000 in 2012. In comparison, the suicide rate among the US military in 2012 was 22.9 per 100,000. Only in 2009 and 2010, the years with the fewest suicide deaths, was the suicide rate among SOF lower than that of the US military.

1.2 Objectives

This report presents the results of the first part of the USSOCOM Suicide Psychological Autopsy project: analyzing the prevalence of suicide among SOF. Specifically, two research questions are addressed below:

- How does the trend in suicide among SOF compare to that of the rest of the military and the general US population?
- What are the demographic characteristics of SOF members who die by suicide?

2. Methods

In this study, the term "Special Operations Forces" includes operators and enablers (including support personnel) who serve as part of the Unified Combatant Command charged with overseeing the various Special Operations Component Commands of the Army, Marine Corps, Navy, and Air Force. The methodology for the prevalence study is presented below.

2.1 Method for the Prevalence Study

The prevalence study involved a data analysis effort of suicides among SOF between January 1, 2007 and December 31, 2015. Data on suicide among SOF was obtained from USSOCOM records. Civilian data was obtained from the Centers for Disease Control and Prevention (CDC) and military suicide data was obtained from annual and quarterly publications of the Defense Suicide Prevention Office. Demographic characteristics of suicide deaths among SOF was analyzed. Categories with fewer than five suicides were not analyzed or included in this report as any rate calculation would be extremely unstable. In addition, Human Subjects' Protection requires that data presented in the report be aggregated to protect individuals' privacy.

3. Results

This section provides key findings of the prevalence study.

3.1 Prevalence

In all, 117 cases of SOF suicides were documented in the time period between January 1, 2007 and December 31, 2015. Due to the statistically small volume of annual data, rates calculated may not be stable. Hence, rate calculations must be interpreted with caution.

Comparison of suicide rates between SOF members and the civilian population must be made with caution. The age and gender make-up of the two populations are very different. SOF has a higher proportion of males, who are at greater risk for suicide. The age range of the SOF population is younger than that of the general population. In addition, exposure to risk factors for suicide is vastly different for civilians and SOF members. While comparison of rates between US military Service members and SOF members are more valid, we would like to point out that the SOF population is unique in the type of missions, operational tempo of their missions, and hence, the nature of stressors and trauma they are exposed to.

With that caveat, Figure 1 shows that suicide rates among SOF members and the US military have been consistently higher than that of the general US population. In addition, suicide rate among SOF members has been higher than the US military since 2012. While there seems to be a downward trend since the peak in SOF suicides in 2012, the rates are still approximately 27% higher among SOF members, when compared with the US military. At the current time, suicide rates for 2015 are not available for the US military and the general US population.

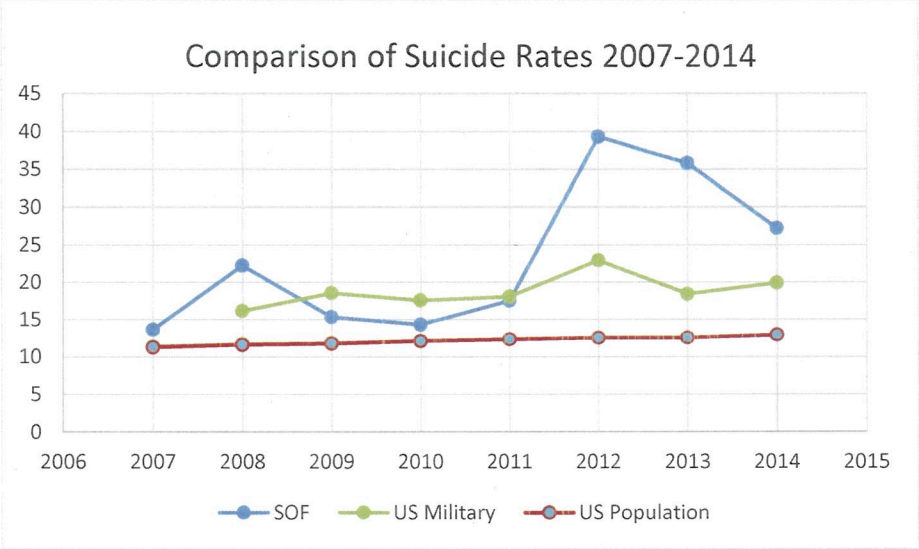

Figure 1 Comparison of Suicide Rates 2007-2014

3.1.1 Gender (N=117)

As noted in Table 1, the Prevalence Study found that SOF members and all military Service Members dying by suicide were more predominantly male when compared with suicides in the general US population. However, the gender distribution of SOF members is 92.1% male and 7.9% female.

Table 1. Comparison of Gender in Prevalence Study and all US Suicides

	SOF 2007-2015 (%)[1]	All Military 2014 (%)	U.S. Suicides, 2014 (%)[2]
Male	113 (96.6%)	73 (91.2%)	77.4%
Female	4 (3.4%)	7 (8.8%)	22.6%

3.1.2 Age (N=79)

The age categories used to report this data was made consistent with those used by the Department of Defense Suicide Event Report (DoDSER) to facilitate comparison. As shown in Figure 2, the Prevalence Study had a higher proportion of individuals who were 25-44 years old, as compared to all military suicides in 2014. There were no suicides among SOF members who were older than 48 years of age. This is in contrast to suicides in the general US population, which occurs most frequently in the 45-59 age group.

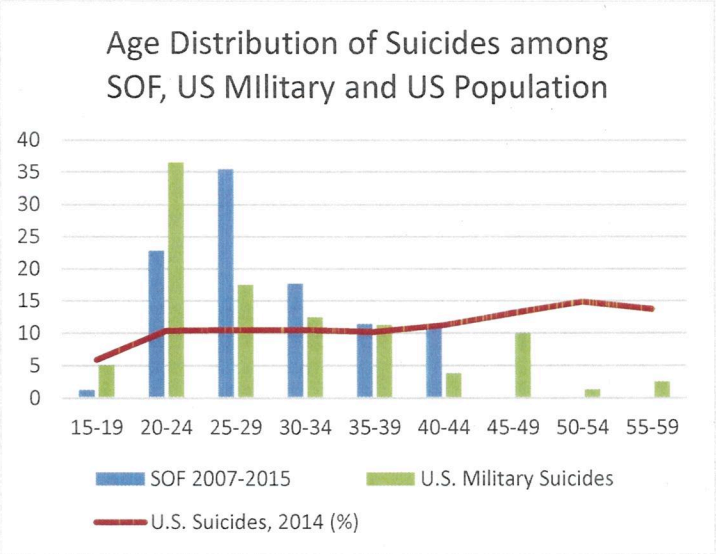

Figure 2 Age Distribution of Suicides among SOF, US Military and US Population

[1] Unstable rate as there were only 4 female suicides in the time period of this dataset.

[2] Centers for Disease Control and Prevention

3.1.3 Race (N=50)

In the US general population, most suicides occur among Whites. However, the rates are highest among American Indian/Alaskan Natives. This was also reflected in the SOF population, where the majority of suicides occurred among Whites. Of the 50 cases for whom race information was available, 40 were White. This reflects the fact that the racial composition of SOF is predominantly White (89.1% among Officers and 80.4% among Enlisted). While there were suicides among SOF members who were Black, Asian, and American Indian/Alaskan Native, the baseline numbers were too low to determine if the difference in rates indicates any correlation between suicide and race.

3.1.4 Grade (N=113) and Service Characteristics

A comparison of the distribution of suicides by grade and rank shows that about 90% of suicides occur among the Enlisted Service Members, both among SOF members and in the overall US military. In USSOCOM, enlisted members comprise 80.6% of the force, but have 90% of the suicides. Among the Enlisted Service members, the greatest number of suicides among SOF were in the E5-E9 grades, whereas the suicides are almost equally distributed across the two groups (E1-E4 & E5-E9) among overall US military suicides. Among SOF members, the distribution of Service Members in the E1-E4 category (35%) and the E5-E-9 category (65%) roughly reflect the distribution of suicide in the two categories (31.5% and 68.5% respectively).

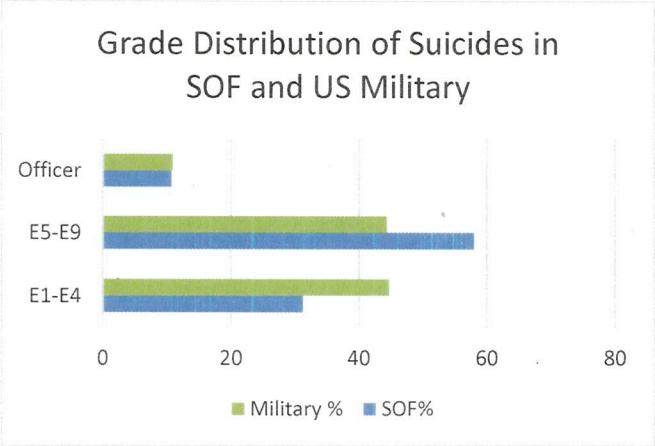

Figure 3 Grade Distribution of Suicides in SOF and US Military

Of the 104 SOF members for whom this data was available, 64 (61.5%) were enablers (including support personnel) and 40 (38.5%) were operators. This roughly reflects the distribution of enablers (62.9%) and operators (37.1%) among SOF members. While data is not currently available for such an analysis, a historical trend analysis can indicate if there is any change in the distribution over time.

Data for time in service was available for 64 SOF members who died by suicide. Time in service ranged from 7 months to 23 years and 10 months. Of these, more than a third (25 members) had been in service for less than five years, and a third had been in service for 5-10

years. Only about a quarter of the SOF members (17 members) who died by suicide had been in service for more than 10 years.

For the 54 SOF members for whom time in grade data was available, the data ranged from zero months to 10 years and two months. Majority of the members (60%) had been in that grade for less than two years, and most of the members (90%) had been in the grade for less than five years.

3.1.5 Marital Status and Relationship Issues

Marriage has been shown to be a protective factor against suicide. On the other hand, relationship issues are a risk factor for suicide. Records show that 29 SOF members who died by suicide had relationship issues. However, without conclusive data showing the number of SOF members who died by suicide and did NOT have relationship issues, we are unable to draw any conclusion at this point. This risk factor is analyzed as part of the psychological autopsy study.

3.1.6 Seasonal Variation

Seasonal variations have been observed in rates of suicide among the general US population. An attempt was made to look for any pattern of seasonal variation in suicides among SOF members. As shown in Figure 4, suicide among SOF members remains remarkably constant through the year, except for a dip in September followed by a spike in October and November. By comparison, among the general population across the world, a study of suicide deaths between 1979 and 2009 showed that suicides peak in spring, especially for violent methods of suicide, with a secondary peak reported in autumn.[3]

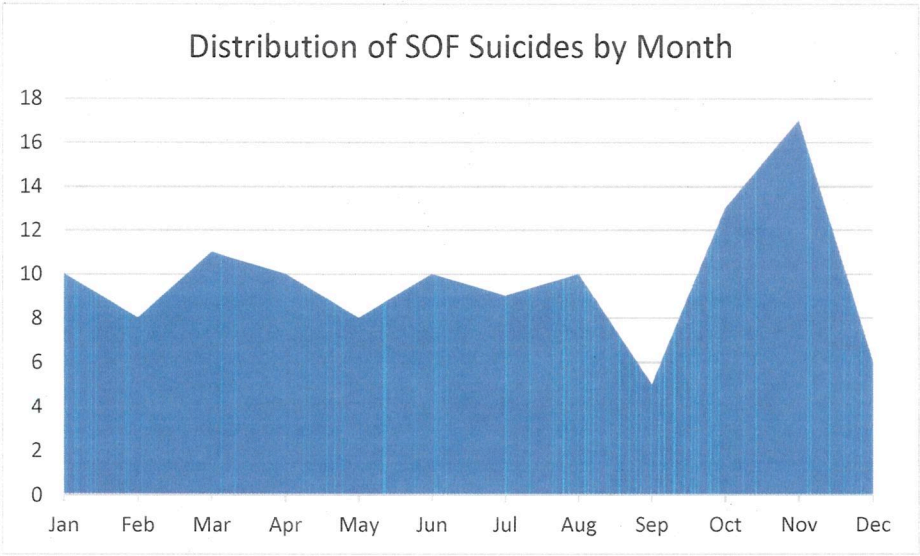

Figure 4 Distribution of SOF Suicides by Month

[3]http://onlinelibrary.wiley.com/doi/10.1111/j.1600-0447.2011.01750.x/abstract , accessed 11/25/16.

3.1.7 Deployment

Deployment data is available for 55 SOF members who died by suicide. Of these, 11 SOF members had never been deployed. About half of the members (23) had been deployed one or two times. A third had been deployed more than two times, including one SOF member who was deployed seven times.

Among the SOF members who were deployed at least once, 73% of the suicides occurred more than six months after return from deployment. All the 10 SOF members who died by suicide within six months of return from deployment had been deployed more than once. Seven of them had been deployed two or three times. While the numbers are too small to look for statistical significance, literature shows that the rates of PTSD among Marines with two deployments was higher when compared with Marines with only one deployment.[4]

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[4] Macgregor A.J., Han P.P., Dougherty A.L., Galarneau M.R. Effect of dwell time on the mental health of US military personnel with multiple combat tours. Am J Public Health. 2012;102(suppl 1):S55–S59.

4. Discussion

As with most prevalence studies, the above results raise important questions and provide directions for further research. There seem to be differences between suicide among SOF members, US military Service Members, and the general US population in age, gender, and seasonal variation. There is no published literature about such differences in suicide characteristics between these groups. Further research is needed to test some hypotheses that may explain the observed differences. For example, the study showed fewer Service Members and SOF members 45 years old and older dying by suicide compared to suicides in general. This could be because most people retire from SOF around this age and the military population of those over 41 years of age is less than 6%.[5]

While the gender distribution of SOF members and suicide risk tend to be predominantly male, the implication for suicide prevention is that to achieve a maximum reduction in suicide numbers, it has to be targeted toward males. Most SOF members who died by suicide were White. This reflects the fact that the racial composition of SOF is predominantly White (89.1% among Officers and 80.4% among Enlisted). While the numbers on minority-SOF member suicides are too low to calculate rates, this finding also points to the fact that to achieve maximum reduction in suicides among SOF members, the programs must reach the members who are White.

The differences noted above between SOF suicides and suicides in general provide areas to determine factors associated specifically with SOF suicides, and hence design appropriate prevention strategies. SOF suicides are statistically rare events. This necessitates reliable and consistent data collection over a longer period of time, so that the findings observed in this study may be validated.

[5] Office of the Deputy Assistant Secretary of Defense, 2014 Deomographics: Profile of the Military Community. Available at http://download.militaryonesource.mil/12038/MOS/Reports/2014-Demographics-Report.pdf. Accessed on January 31, 2017

5. Limitations and Future Directions

While comprehensive data was available on some cases, limited data was available in some key fields such as number of deployments. Similarly, other valuable data, such as relationship issues, were not available through data sources used in this study.

This study provides the first prevalence analysis of suicides among SOF members in the United States. This analysis was possible because records maintained by USSOCOM since 2007 allowed data to be aggregated. The results highlight the gaps in available data and the challenges of collecting these data without a surveillance system. DOD has a surveillance system (DoDSER), but as highlighted by the DOD Inspector General's report, it is limited and is generally incompletely done.[6]

[6] DODIG, Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment, November 2014 available at http://www.dodig.mil/pubs/documents/DODIG-2015-016.pdf. Accessed on January 31, 2017

6. Conclusion

There were reports of 117 suicides among SOF members between 2007 and 2015. A trend analysis shows the suicide rates mirror the trend in the US military, however, the rates of suicide among SOF members has been consistently higher than that of the US military population. The age range of SOF members who die by suicide tends to be lower than that of the US military and the general US population. Most suicides by SOF members occur among the enlisted members in the E5-E9 grades. The monthly variation of suicide among SOF members follows an interesting pattern with a spike in suicides during the October and November months.

Further research and an improved data surveillance system are needed in order to better understand the risk and protective factors for suicide among SOF members. Further research and a comprehensive data system is needed to monitor the demographics and characteristics of SOF members who die by suicide. With a clearer picture, countermeasures may be designed to prevent these tragic fatalities.

7. Future Direction and Activities

This study has demonstrated the need for an ongoing surveillance system to report and monitor suicides among SOF members. Additionally, the data emerging from this study has highlighted the need for research to better understand the factors associated with SOF suicides.

Section II: Psychological Autopsy Study Report

8. Introduction

8.1 Background

The issue of suicides among SOF members has not been well researched. It is unknown whether SOF individuals who decide to end their life are unique with regard to risk factors and warning signs. An understanding of these variables will enable the design of effective prevention strategies for suicides among SOF members. The Psychological Autopsy Study attempts to improve the understanding of SOF suicides by researching into risk factors and warning signs. The study was intended to generate the maximum possible amount of information about each decedent to provide an understanding of SOF suicides and to inform prevention efforts.

While the psychological autopsies help us understand the characteristics of SOF individuals who died by suicide, we have no comparison with a matched sample of SOF individuals who did not die by suicide. While this study provides the first insight into the issue of suicides among SOF members, it may not be sufficient to help determine whether the risk factors and warning signs seen in this study are unique to SOF members. This report will discuss the sufficiency of the findings/trends observed from these cases and whether meaningful results/conclusions can be made. Potential prevention strategies, based on the findings of this study, are presented. AAS conducted this study under contract to USSOCOM.

8.2 Introduction to the Psychological Autopsy

In 1958, Edwin Shneidman, Norman Farberow, and Robert Litman – then directors of the Los Angeles Suicide Prevention Center (LASPC) – coined the term "psychological autopsy." These clinician-researchers, working in collaboration with the Los Angeles County Medical Examiner's Office, devised a set of procedures to assist the medical examiner (ME) in medico-legal investigations where the ME could not readily determine the manner of death (suicide, homicide, accident, or natural). Since then, the psychological autopsy has evolved into a "best practice" investigative tool to establish causal factors leading to suicides. Where deaths have clearly been determined to be suicides, the psychological autopsy can identify distal and proximate risk factors, identify points of entry along the decedent's pathway to suicide (where intervention could have been/might be possible), and help survivors cope with the "Why suicide?" question through answers given by and information uncovered from its sources of data.

The psychological autopsy is a systematic method to collect retrospective psychological and related data about the decedent through interviews with knowledgeable associates (typically family members, friends and co-workers/students); and analyses of archived documents and records of the decedent's life (e.g., health records, criminal records). Investigators seek relevant data that provide insight regarding the decedent's characteristic behavior, personality, coping style, etc., to form a biography of the individual. When combined with reported observations of the decedent's last days of life and evidence from the site of death, an understanding of the suicide emerges. When aggregated with similar suicides (in this case, among SOF members), findings can highlight common factors aiding the choice and implementation of measures that could be used to prevent suicides in this population. The psychological autopsy is a tool used in the psychological study that is part of the project, as shown in Appendix A.

This report discusses aggregate findings from 29 psychological autopsies of USSOCOM members who died by suicide between January 1, 2012 and December 31, 2015. Aggregate findings from these psychological autopsies were used to provide an understanding of modal causal factors that characterize these decedents (thus, an understanding of who may be at risk in the future), to understand why suicides occur among USSOCOM members, and to suggest potential prevention strategies. This last goal is the next step in this project, i.e., to translate what has been learned into interventions to reduce the incidence of these suicides. Both distal (lifetime) and proximal (near-term or acute) risk factors discerned from these autopsies enable the understanding of why these decedents were vulnerable to dying by suicide, what compelled them to take their lives at the time of their suicides, what was observable to others that might inform early detection of impending risk, and whether there are unique factors associated with USSOCOM members that might have influenced their choice to end their lives.

While the results of this study are presented in an aggregate form, it is important to bear in mind that every suicide is a unique event.

9. Background

9.1 Historical Context

The psychological autopsy study of suicide by SOF members is a milestone in the field of suicide research for two reasons; it is the first study that tries to understand SOF members who die by suicide and it is the first study that applies the psychological autopsy process to suicide by SOF members. In fact, a literature review yielded no articles on suicides among SOF for United States forces or their allies.

A psychological autopsy provides the closest approximation that a researcher can reasonably obtain on the mental state of an individual who dies by suicide. A psychological autopsy, when conducted with trained researchers and a standardized protocol, is the most thorough method to obtain an in-depth understanding of the circumstances that led to each suicide and presents an opportunity to look for commonality across the SOF members who died by suicide.

9.2 Current Study

Based on USSOCOM records, there were 117 suicides amongst SOF between 2007 and 2015. This ranged from a peak of 23 suicides in 2012, to a low of six suicides in 2007 and 2010. Since the peak in 2012, the number of suicides amongst SOF has been trending down, but remains significantly higher than the numbers seen in 2007 and 2010. While the annual numbers may seem small, the rate of suicide amongst SOF was as high as 39.3 per 100,000 in 2012. In comparison, the suicide rate among the US military in 2012 was 22.9 per 100,000. Only in 2009 and 2010, the years with the fewest suicide deaths, was the suicide rate among SOF lower than that of the overall US military. While it was beyond the scope of the current study, a future study comparing the suicide rates among SOF members with a sample matched in age and rank in the overall US military is recommended.

10. Methodology

10.1 Psychological Autopsy Procedures

As noted above, the psychological autopsy is a tool used to reconstruct a decedent's life to determine the causes, mechanisms, and, if undetermined, the mode or manner of death. It relies primarily on the identification and cooperation of knowledgeable informants, typically next of kin. The psychological autopsy has a wide amount of published peer reviewed literature, which indicates that the procedure is one accepted by the scientific community.[7] Data from the psychological autopsy cannot be objectively validated as the findings cannot be confirmed by the decedent.[8] As one example, what appears to be an impulsive suicide to the next of kin, may well have been planned by the decedent, yet if no clues to that planning were left, then this information could only be confirmed by the decedent, which is no longer possible. Researchers are of different opinions about the use of proxy informants, about whether a single informant (interviewee) is acceptable versus as many as are necessary to fully develop an understanding of what happened, about the ideal length of time between death and interview, about whether multiple interviewees (versus single interviewees) may be conjointly interviewed, etc. When the psychological autopsy is conducted by trained interviewers with a background in the behavioral sciences that are using a standardized protocol, the issue of inter-rater reliability is seen to be minimal. These methodological considerations have yet to be worked out by the research community. However, it does not compromise the value of the procedure to derive meaningful aggregations of postmortem reconstructions of decedents' lives in order to inform prevention.

In this study, the term "Special Operations Forces" includes operators and enablers (including support) who serve as part of the Unified Combatant Command charged with overseeing the various Special Operations Component Commands of the Army, Navy, Air Force, and Marine Corps, of the United States Armed Forces. USSOCOM shared demographic data about suicides among USSOCOM members. AAS conducted a systematic selection and intensive training of field investigators. Next of kin willing to participate in the psychological autopsy study were identified and paired with a psychological autopsy investigator located nearest to their residence. Face-to-face meetings were scheduled to conduct the psychological autopsy interviews. Before completing interviews with next of kin, all of those interviewed were asked to review and sign a confidentiality statement letter to indicate that they were aware the data would be held confidential and that they had the right to withdraw from the interview at any time. They were also asked to sign release forms to allow investigators to request archived records (such as medical records and government records) and to identify other potential informants presumed to be knowledgeable about the decedent. The process of contacting them began anew until the researchers made the decision to stop soliciting additional interviews. By protocol, researchers stopped soliciting additional interviews when one of the following two scenarios occurred:

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[7] Berman, A.L. (2005). Forensic psychiatry and the psychological autopsy (pp. 364-371). In J. Payne-James (Ed). Encyclopedia of Forensic Psychiatry and Legal Medicine. Amsterdam: Elsevier.

[8] Berman, A.L. (2005). Forensic psychiatry and the psychological autopsy (pp. 364-371). In J. Payne-James (Ed). Encyclopedia of Forensic Psychiatry and Legal Medicine. Amsterdam: Elsevier.

1. All the questions in the protocol were answered and corroborated by information from multiple sources and the questions that the study set out to answer (Why suicide, Why at this time, Why suicide by that method, How could it have been prevented) were addressed.
2. There were no other informants who had any further information about the decedent or who were willing to be interviewed.

For the final sample of 29 cases reported in this report, additional interviews were stopped due to the former scenario.

The psychological autopsy interview involved a semi-structured protocol developed specifically for this study (see Appendix B: *Psychological Autopsy Protocol*) and approved by both the Office of Human Protections Research and the Western Institutional Review Board to safeguard against any harm to survey respondents.

Researchers[9] conducted interviews with the next of kin and friends to obtain the information required to complete the protocol and answer the study questions. It was preferred that interviews be conducted individually, however, in some cases, family members felt strongly that they needed another family member to support them throughout the interview. In such cases, researchers used their professional judgment as behavioral health experts to watch for any interpersonal dynamics that indicated that the respondent was inaccurate or less than forthcoming and followed up at a later time with the respondent.

Each case was handled in its entirety by one researcher. This helped to piece together the different aspects of the decedent's life. Researchers took notes during the interview. However, they did not record the interview so as to be sensitive to the emotional and deeply personal experience it was for most survivors to relive the memories of their loved one. Researchers made every attempt to verify the information provided by the interviewees by seeking corroboration from other interviewees and asking for evidence where appropriate. For example, when a family member reported that the decedent suffered from mental illness, researchers sought prescription records and any medical records that the interviewee had access to. These records were used to verify the presence of mental illness, the diagnosis where applicable and whether the individual was seeing a healthcare provider. Only verified diagnoses of mental illness were reported.

When the researcher completed the protocol on a case, it was reviewed by the Research Director for quality control. The researcher was asked to respond to any questions that were raised during the review. While an average of two questions was raised per case, the researchers had the answers to these questions in their notes. In no instance were further interviews conducted.

A detailed explanation of the study's procedures follows.

10.2 Case Identification Procedures

The potential case population was derived from data available regarding USSOCOM suicides within
the 4-year study timeframe (January 1, 2012 through December 31, 2015). The potential

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[9] See Appendix G for researchers who conducted the interviews.

universe of interviewees consisted of friends, coworkers, and family members of the decedent. The Project Coordinator maintained a password-protected electronic document on the local hard drive with the master list of potential interviewee names and assigned randomly generated identification numbers to cases.

USSOCOM provided a list of 70 cases that were ruled as suicide and occurred within the study timeframe. A copy of the incident report and decedent's death certificate was obtained. While researchers did not engage loved ones in a discussion of whether the death was a suicide, there was a need to be absolutely certain that the death had been ruled as a suicide. Hence, this study conducted psychological autopsies on only the cases where project staff could obtain verifiable evidence that the death was determined to be a suicide.

From information contained in these reports, data elements were compiled. These elements consisted of personal and demographic information about the deceased (e.g., home address, age, gender, ethnicity), as well as the date/time, manner, and location of the death. This information, along with additional data found through public sources (see below), was used to identify the family of, and other potential persons knowledgeable about, the decedent.

A letter was then sent to the next of kin. The letter introduced the project and assured respondents that data gathered and processed for the purpose of this study would be released by AAS to USSOCOM in generalized summary reports, and that AAS would not release any of the raw (individual-specific) data provided to USSOCOM or DoD. The packet included a project description and a letter of introduction from the USSOCOM Commander as a confirmation of AAS official status as performer of this USSOCOM-funded research.

The letter was followed up by a telephone call placed by the research team to request a face-to-face meeting for the interview. If the next of kin agreed to participate, an investigator was assigned to the case and asked to make contact within 24 hours to set up an appointment. Investigators contacted the next of kin to arrange a meeting and traveled to the place of interview designated by the next of kin. During the two weeks after the letter was sent, but prior to the interview, AAS research assistants searched the Internet (e.g., media reports, blog posts, obituaries, people locator, and social networking sites) for additional information about the decedent and the incident. This information was used to identify additional friends and family who could be contacted for interviews.

By telephone and in person, the next of kin were asked if there were any friends, teachers, co-workers, or significant others that could provide further information. The investigators also used USSOCOM reports, police reports and medical examiner's reports and the information provided by AAS staff to identify and locate other potential respondents. The first *National Strategy for Suicide Prevention*[10] states that for every suicide, there are six to eight individuals who have been closely associated with the person who has died by suicide. Hence, of this potential universe of respondents, a maximum of eight individuals was planned for regarding any one decedent. The selection of individuals to be interviewed was based on their presumed knowledge of the decedent (using criteria such as proximity, duration and recency of relationship with decedent), and of the events leading up to his/her death.

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[10] U.S. Department of Health, May 2001

10.3 Interviewee Protections

Interviewers were required to have a background in the social sciences and were trained to identify and deal therapeutically with any possible negative psychological consequences from the interview. A list of interviewers and their qualifications is included in Appendix G. Interviewers were trained in supportive interviewing techniques and the study protocol. Every interviewer received approximately 24 hours of standardized psychological autopsy training before they were assigned a case. In this training, individuals were provided information about psychological autopsy studies, the study methodology and background. They were trained on how to obtain information for each question on the semi-structured protocol and were asked to role-play the interview. Researchers were also provided 14 hours of in-service trainings on monthly telephone calls between November 2015 and December 2016. During this updated training, researchers built on their practical knowledge, such as responding to commonly encountered challenges, and improving their data reporting so as to minimize additional questions during case review. These trainings also allowed researchers to share process information and tips on obtaining the best quality data, while simultaneously being sensitive to the needs and emotional status of the interviewees. While researchers were each asked to provide an update on their cases, the primary goal of these calls was for training rather than oversight. The Project Coordinator had phone conversations, as needed, with each researcher separately for oversight purposes. Researchers also had the liberty of reaching out to the Project Coordinator or Research Director at any time.

If an individual appeared distraught during the interview, the interviewer was instructed to stop the interview, assess the individual's distress level, and take appropriate steps to alleviate the individual's distress. To assist individuals who requested psychological help, the interviewers were trained to provide suggestions for professional help and to direct the interviewee to sources of information on mental health providers in the local area. In cases in which an interviewee expressed suicidal ideation, the interviewer was trained to evaluate the severity of the interviewee's suicide risk, provide counseling support, encourage him or her to call the national hotline, and to provide information to enable that individual to receive professional help.

Across all cases in this sample, no interviewer needed to utilize these procedures, or to respond to and intervene as his or her training specified.

Additionally, interviewers closed each interview by providing survivor support information, such as a list of support groups in the local area of the interviewee.

10.4 Consent Procedures

In order to allow time for next of kin, friends and co-workers of the decedent to move past the initial shock of the death being investigated, project staff made sure that a minimum of six months[11] passed after the death had been ruled a suicide before attempting to recruit them to participate in this study. Based on the timeline of this project, the maximum time period

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[11] While progress through the grief process varies by individual, project staff who had lost loved ones to suicide and the Principal Investigator agreed that six months would be a reasonable time to be sensitive to the interviewees' grief.

between the suicide incident and the interviews was 4 years. If initial consent to participate was given, a member of the research team spoke to the potential interviewee, provided information about the study and obtained active consent to participate. All research staff members participating in the consent process were trained in National Institutes of Health Human Subjects Protection procedures and were under the direct supervision of the Research Director.[12] At the time of consent, the nature of the study and potential risks and benefits were discussed. Potential interviewees were provided time to ask questions and were offered a summary of the research protocol. Interviewees were asked to sign a consent form. Interviewers emphasized the message that had been already transmitted in the initial telephone contact: that a respondent could stop the interview at any time. Only family members and friends who understood the informed consent procedure were included in the study. Children under 18 years of age were not interviewed due to human subjects protection requirements.

10.5 Authorization Procedures

Families were asked to sign a standard written authorization for project staff to obtain the decedent's health records from healthcare providers. For all the cases studied, next of kin provided this authorization. The consent was in the form of written documentation providing release to treatment providers and hospitals to share available health information with the project staff. This consent was obtained in all cases and USSOCOM was able to provide medical records for 17 cases.

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[12] Certification of all project staff by the National Institute of Health was a prerequisite for this project to obtain clearance from the Institutional Review Board.

11. Results

11.1 Study Population and Sample

Table 2 summarizes how the sample of 29 cases analyzed in this report was derived from all identified cases of USSOCOM suicides during the study period. Of the 70 cases of suicides identified by USSOCOM and confirmed by death certificates, there were identified next of kin for 65 cases. This resulted in 65 letters being sent to next of kin, describing the project and requesting their participation. In 14 of these cases, there was no response to the letters or follow-up telephone calls. Next of kin of 10 decedents refused to participate in the study. Next of kin of 41 cases agreed to be interviewed. Of these, 12 next of kin changed their mind prior to the interviews being scheduled. Interviews on each case were generally conducted over a two-week period depending on the respondents' availability and convenience. Researchers were given one week from the date of the final interview to submit the completed protocol and supporting documentation for review. The Research Director reviewed and discussed the cases within two weeks of the cases being submitted for review. Analysis was conducted on the final sample of 29 cases. A total of 81 interviewees provided data, resulting in a mean of 2.8 interviewees per case. As explained in Section 3, the objective was to obtain complete information about the case and answer the study questions. All informants were asked questions from the entire protocol. Responses were gathered from all the informants who agreed to be interviewed. Researchers used all the information gathered to complete the protocol and develop a cohesive picture of the decedent. When there were gaps, the researcher scheduled additional interviews. Information provided by multiple informants was used to corroborate and hence verify the data gathered. Based on the specific data element, different respondents were presumed to have the most accurate information. e.g. parents and siblings, rather than the spouse, were more likely to know about any history of mental illness during childhood. When there was lack of clarity or conflicting information provided, researchers sought clarification from the interviewees. Cases varied in the number of key informants needed to obtain all the information needed to complete the protocol and gather a cohesive picture. At the conclusion of the interview, protocol required researchers to offer contact information for local support groups and mental health providers to the interviewees. This information was offered to all 81 interviewees. There was no further follow-up to determine whether the interviewees actually sought help.

Table 2. Derivation of Study Sample from Total Identified USSOCOM Suicides

Description	Number	Notes
Total identified cases between January 1, 2012 and December 31, 2015	70	Project Case list
Total confirmed cases	70	Cases determined suicide by Medical Examiner (ME) report or death certificate
Number of families (cases) sent letters	65	
Number of cases for which there was no reply	14	Sent letters, but despite a minimum of 6 telephone calls over 2 weeks, researchers were unable to make contact
Number of next of kin (NoK) who refused to participate	10	Declined responses from NoK in which the cases were not able to be completed
Number who consented	41	NoK agreed to participate; this includes cases for which the interview with consenting NoK never happened
Number of families scheduled to be interviewed	29	12 NoK changed their minds, backing out following their initial consent
Number of cases interviewed	29	
Completed cases that did not meet quality screen of being able to answer the research questions outlined in Section 3	0	Respondents did not have sufficient recent contact to provide necessary information
Final Sample	29	

11.2 Process Measures

11.2.1 Next of Kin

In conducting psychological autopsy interviews, researchers found that next of kin that agreed to be part of the study were eager to share information and observations about the life experiences of their loved ones. In many cases, the expected one-hour planned timeframe to complete the psychological autopsy protocol extended to two hours or more. Further, a number of interviewees, at the conclusion of the protocol, said to the investigators – or contacted the research team to say – that the experience was helpful to them in processing their grief. Our experience was consistent with what was reported in the literature. For example, a study that looked at participation in psychological autopsies as therapy concluded that the psychological

autopsy is helpful to interviewees – providing them with meaning and insight into their loved one's death, offering psychological support, and encouraging acceptance.[13]

11.2.2 Researchers

We also obtained feedback from researchers about their reaction and experiences to conducting the interviews. The researchers indicated that the in-person interview required a number of high-level skills, all operating simultaneously, i.e., constantly assessing the respondent's level of comfort or distress, recognizing and setting aside one's own reactions to the respondents and to the story, and determining a strategy to get the best and most complete information possible.

Interviewers encountered emotional situations and, therefore, experienced some emotional responses. At times, they reported, it was overwhelming because of the unpredictability involved in each interview and the need to assess and respond on the spot. Sometimes there was reticence or resistance, particularly if family members felt that the interviewers represented the Department of Defense system that had failed their loved one. In such cases, the researcher was able to obtain the necessary information by keeping the focus on the eventual goal of the study – to prevent such suicides. While these are experiences reported by interviewers, it did not detract from their work as trained mental health professionals.

Overall, interviewers reported that the interview gave the family the opportunity to tell their stories, to feel heard, and to contribute to the larger cause of suicide prevention.

11.2.3 Medical Providers

Families were asked to sign a standard written authorization for project staff to obtain the decedent's health records from USSOCOM. For all the cases studied, next of kin provided this authorization. The researchers handling each of the cases were given the medical records to help inform the psychological autopsies, verify, and supplement the medical information provided by next of kin. Given recent privacy protection legislation, notably the Health Insurance Portability and Accountability Act of 1996, health and social service providers generally do not participate in psychological autopsy studies unless compelled by a legal subpoena. Unlike prior psychological autopsy studies, this study benefitted greatly from USSOCOM's ability to obtain medical records.

11.3 Demographic Characteristics of Study Sample

While the study period of the psychological autopsy study was January 1, 2012 to December 31, 2015, USSOCOM was able to obtain demographic information for all suicides from 2007 – 2015. Hence, the Prevalence Study analyzed all SOF suicides for this time period. In all, 117 cases of SOF suicides were documented in the time period between January 1, 2007 and December 31, 2015. Due to the statistically small volume of annual data, rates calculated may not be stable. Therefore, rate calculations must be interpreted with caution.

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[13] Henry, M., Greenfield, B. J. (2009) Therapeutic effects of psychological autopsies: The impact of investigating suicides on interviewees. *Crisis, 30*(1), 20.

Comparison of suicide rates between SOF members and the civilian population must be made with caution. The age and gender make-up of the two populations are very different. SOF has a higher proportion of males, who are at greater risk for suicide. The age range of the SOF population is younger than that of the general population. In addition, exposure to risk factors for suicide is vastly different for civilians and SOF members. While comparison of rates between US military Service members and SOF members are more valid, we would like to point out that the SOF population is unique in the type of missions, operational tempo of their missions, and hence, the nature of stressors and trauma (physical, moral and ethical) they are exposed to.

As noted in Table 3, the Prevalence Study found that the SOF members dying by suicide were mostly male. Of the 29 members included in this study, all decedents were male. The difference between the SOF suicides and the study population is not statistically significant. X^2 (2, N=29) =1.02, p = 0.31266.

Table 3. Comparison of Gender in Prevalence Study and Psychological Autopsy Study

	SOF 2007-2015 (%)[14]	**SOF PA Study**
Male	113 (96.6%)	29 (100%)
Female	4 (3.4%)	0 (0%)

The age categories used to report this data were made consistent with those used by the DoDSER to facilitate comparison. As shown in Figure 5, the Prevalence Study had a higher proportion of individuals who were 25-44 years old, as compared to all military suicides in 2014. There were no suicides among SOF members who were older than 48 years of age. The Psychological Autopsy Study population reflects all suicides among SOF members in having the majority of suicides in the 25-44 age group. The age range of the decedents studied was 19 to 48 years.

[14] Unstable rate as there were only 4 female suicides in the time period of this dataset.

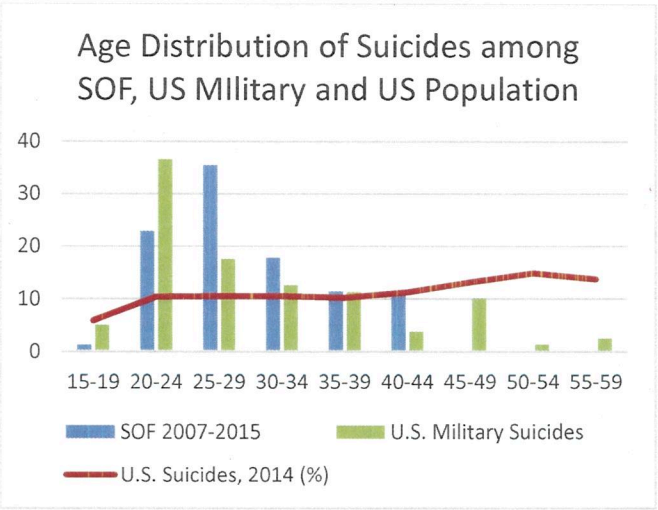

Figure 5 Age Distribution of Suicides Among SOF, US Military and US Population

With regards to marital status at the time of death, 8 (27.6%) were single, 6 (20.7%) were divorced or separated; and 14 (48.3%) individuals were married. While recent national surveillance data are not available for comparison, the studied population is similar to the findings in a 1988 study that analyzed U.S. suicide rates over a three-year period and found that 47% were married, 29% were single, 9% were widowed and 15% were divorced.[15]

More than half of the decedents had children; 16 (55.2%) decedents had children. As would be expected for the military population, all the decedents studied had at least high school education, with 16 (55.2%) having at least some college education.

11.4 Geographic Representation of Study Population

While the cases studied were posted at bases across the country, the largest number of incidents in the study sample has been found to be among SOF members posted at Ft Bragg, NC, Joint Base Lewis McChord, WA and Ft Campbell, KY. Most suicides occurred when the SOF members were at their duty location. The states where most of these suicides occurred were North Carolina and Washington. The other 15 cases were distributed across 11 states. When viewed overall, as seen in Section 4.5 below, the geographic distribution of the sampled cases appears to follow the general pattern of all SOF suicide cases that have been confirmed as suicides. Most suicides 18 (62.1%) occurred when the SOF members were off base.

11.5 Representativeness of Study Population

The sample of 29 autopsied cases compared to all confirmed SOF suicide cases in the Prevalence Study (N = 117) between January 2007 and December 2015 is as follows:

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[15] Smith et al. (1988) Marital Status and the Risk of Suicide, *American Journal of Public Health, 78(*1).

11.5.1 Age

The mean age of all confirmed cases was 28.2 years, while the median age for the 29 autopsied cases was 29 years. This difference is not statistically significant. Two-tailed P value = 0.952273.

11.5.2 Gender

Of all the confirmed cases, 113 were male and 4 were female. Among the autopsied cases, 29 were male and there were no females. The study sample's gender distribution is not significantly different from the population from which it was derived. X^2 (2, N=29) =1.02, p = 0.31266.

11.5.3 Race

In the sample of autopsied cases, the majority of the decedents were White 19 (65.5%) cases. However, race information was unavailable for 67 cases in the SOF suicide population data. Therefore, it is not possible to compare the autopsied population with the overall SOF suicide population. However, the fact that an overwhelming majority of the autopsied cases is White is consistent with suicides in general where 91% of suicide decedents are White.[16]

11.5.4 Geographic Distribution

The following, Figure 6, locations of the autopsied cases, shows the distribution of cities with cases autopsied in this study.

Figure 6 Autopsied Cases

As mentioned earlier, the distribution of the cases in this sample reflects the duty locations of the SOF members with the most number of suicides – Ft Bragg, NC, Joint Base Lewis McChord, WA and Ft Campbell, KY.

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[16] Centers for Disease Control and Prevention, WISQARS

Figure 7 shows the distribution of confirmed SOF member suicides between January 2012 and December 2015. Each point may represent more than one case if multiple suicides occurred in a city within the study period. A visual comparison of the two maps shows remarkable similarity between the distribution of all confirmed cases and the sample.

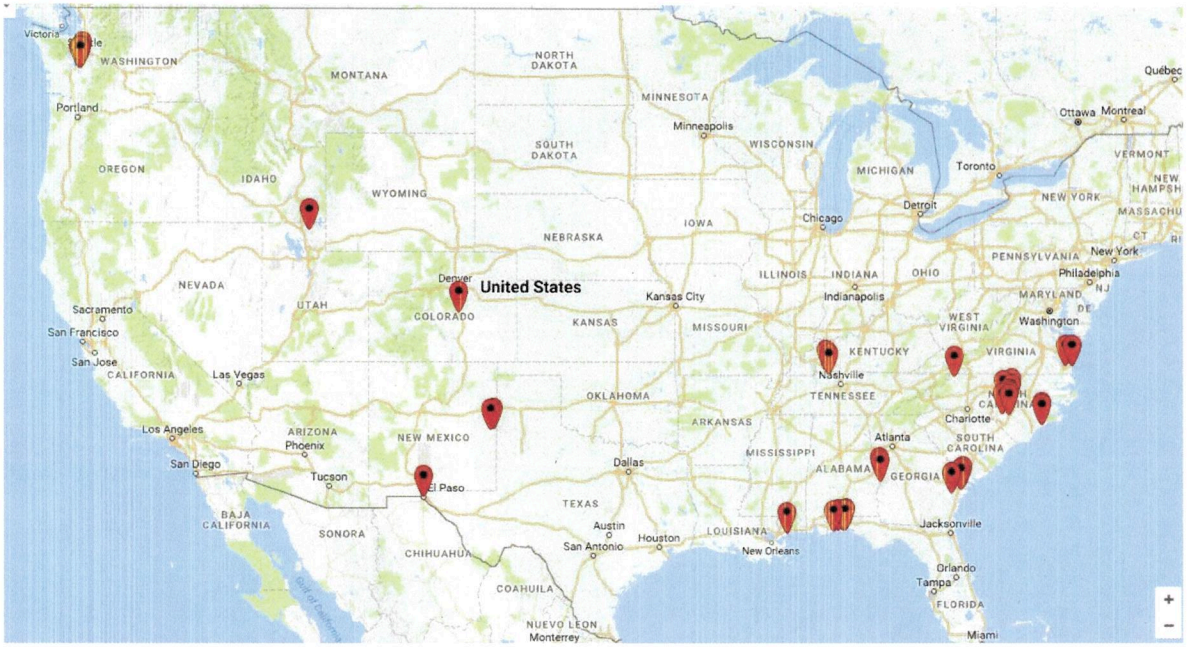

Figure 7 Confirmed SOF Member Suicides

12. Discussion of Findings

12.0 Results

The findings based on the data gathered from 29 psychological autopsies follow.

12.1 Connectedness with the Military

Almost half (48.2%) of the SOF members felt a strained connection to the military within six months prior to their deaths. The reasons varied: the decedents were having problems with their supervisor and unit colleagues; upcoming transfers were going to move them away from the community to which they were connected; duty reassignments, demotions or pending disciplinary actions; additional work requirements affected time with family.

As these changes occurred within six months of the decedent's suicide, monitoring SOF members' feeling of connectedness with the Military and their Unit may serve as a warning sign for suicide.

12.2 Deployments

Most of the decedents, 21 (75.8%) in the study, had been deployed at least once. Of those deployed, 16 SOF members had deployed 2-4 times. Among the decedents who had deployed, at least 12 of them had shared with their loved ones that they had been in combat situations and were mentally affected by their experience. Some of the experiences shared include being under enemy fire, colleagues dying by Improvised Explosive Devices (IEDs), handling human remains, killing enemy soldiers, killing animals, witnessing/participating in detainee torture and death, and missions that went against the decedent's ethical beliefs. Only 5 of the decedents were known to suffer physical injuries in combat. However, in 8 cases, next of kin believed that the decedent had suffered a traumatic brain injury (TBI).

While there is no proven direct link between their mentally traumatic experience and their suicide, the shared experience by a majority of the deployed SOF members presents an area for further research and possibly early intervention. Re-evaluation of the protocol to rule out TBI may also be indicated.

12.3 Financial and Relationship Issues

More than half of the decedents 17 (58.7%) had financial problems at the time of their death. In 15 (51.7%) cases, the financial problems started within 6 months of the decedent's suicide. The most common reason for financial problems, seen in 8 (27.5%) cases, was the result of relationship issues with current partner, former partner, and/or extramarital partner.

> "The role of the SOF wife is to uphold her husband's reputation, never revealing any problems." – Psychological Autopsy Respondent

Depending on the quality of the relationship, it is generally understood that being in a relationship with a significant other is a protective factor, i.e., those in a relationship tend to have a lower risk of suicide than those not in

a relationship. However, the protection offered by a relationship is moderated by the quality of that relationship. A relationship in conflict, under threat of separation, etc. is not protective. Of the 29 decedents, 21 (72.5%) were in a relationship at the time of death. However, 15 of these individuals were having relationship issues at the time of death. In 11 cases, the relationship issues started within a year of the decedent's suicide.

While relationship issues seem very prevalent among the SOF members who died by suicide, there is no comparable data on relationship issues among SOF members who did not die by suicide. The events of the week leading up the death show volatility in the relationship and trigger events such as a fight or a break-up. However, the narrative of the relationship breakdown indicates the need for more upstream prevention that focuses on creating and maintaining healthy relationships.

12.4 Mental Illness, Co-morbidity, and Treatment

A mental illness is a psychological or behavioral pattern in an individual that causes distress, disability, or dysfunction and is not expected as part of normal development or culture. Co-morbidity is the presence of two or more co-occurring diagnosable mental illnesses. Mental illnesses are diagnosed according to criteria in the form of symptoms, feelings, thoughts, or behaviors either observable to or reported by the individual to others.

Respondents reported that 13 (44.8%) of the SOF members in the study had a diagnosed mental illness. Due to unavailability of all medical records, independent confirmation was available for a mental illness diagnosis for 11 decedents. Approximately a third of these 11 decedents (36.4%) were diagnosed with depression.

A number of near-term (acute) risk factors for suicide have been identified in prior research. Several of these have been identified by expert consensus as specifically associated with near-term risk for suicide[17] and captured by the acronym: IS PATH WARM?
(I = Ideation, S = Substance Abuse, P = Purposelessness, A = Anxiety, T = Trapped, H = Hopelessness, W = Withdrawal, A = Anger, R = Recklessness, M = Mood Change).[18] In this study, 18 (62.1%) decedents had been observed to have at least one of the IS PATH WARM signs, with 13 (44.8%) of them exhibiting more than one sign. The most common signs were Anxiety 10 (34.5%), Withdrawal 10 (34.5%), Feeling Trapped 8 (27.6%), and Hopelessness 8 (27.6%).

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[17] Rudd, M.D., Berman, A.L., Joiner, T.E., Nock, M.K., Silverman, M.M., Mandrusiak, M., Van Orden, K. and Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36* (3), 255-262.

[18] I stands for suicide ideation (thoughts) expressed in words or other communications or threats. S stands for excessive or increasing use of alcohol or illicit drugs (substance use). P stands for a sense of lacking purpose or meaning in life. A stands for anxiety, agitation, or problems in sleeping (insomnia). T stands for feeling trapped, like there's no way out. H stands for feelings of hopelessness, having no expectation that things will change for the better in the future. W stands for withdrawal, from finds, school or work, usual interests and activities – an increased sense of isolation. A stands for excessive anger (rage) or expressions of wanting revenge. R stands for recent reckless or excessively risky behavior, as if one had no concern for its consequences. M stands for dramatic mood changes.

Only 11 (37.9%) individuals were known to be in therapy at the time of death. Significant barriers to seeking care were observed by the respondents. The most common barrier was the fear that reporting mental health issues or suicidal ideation could lead to being separated from their unit or singled out for problems. This fear also prevented loved ones from sharing their concerns about the SOF member's mental health. Hence, despite having access to mental health care, these SOF members were unwilling to seek care from military providers. Some commonly shared comments were: seeking therapy would threaten the decedent's career, assignments and ability to be promoted; the military discouraged seeking mental health care; mental illness is seen as a sign of weakness; did not want to use military resources and could not afford private therapy.

In at least one case, the SOF member is believed to have reported suicidal thoughts to Unit leaders but was sent home and told to return the following week. In another case, the SOF member sought counseling upon the loved one's insistence but refused medication for fear of losing his security clearance. Respondents agreed that Chaplains are able to provide some assistance without directly or explicitly informing those in command of the soldier's issues, however they also believed that even chaplains sometimes share information with commanding officers.

> "He saw that individuals who shared having suicidal ideations were escorted like a criminal for evaluation." – Psychological Autopsy Respondent

Military leadership statements that encouraged help-seeking were viewed as disingenuous based on their experience observing the way SOF members who have sought help were being treated at the Unit level.

The role played by mental illness in SOF suicides is different from that in the civilian world. Among civilian decedents who end their life by suicide, 62% are reportedly taking prescription medications for mental health problems.[19] While the severity of mental illness among SOF members who die by suicide is likely lower than that of their civilian counterparts, access to care plays a very prominent role. Changing the military attitude at the Unit level towards suicidal individuals is key to addressing this issue. Some suggestions the respondents had to improve suicide prevention training were to include in-person training, role playing to recognize warning signs and risk factors, responding to suicidal individuals in a non-stigmatizing manner, and including suicide survivors in the training.

12.5 Goodbye Behaviors

In the general population, surviving family members and friends of decedents often observed behaviors that appeared to suggest that the decedent was saying goodbye in the days before his or her suicide. Some were clear indicators of the decedent bidding farewell to family and friends – some, in positive ways. However, these behaviors were only recognized after the fact.

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[19] Perkins, R., Sanddal, T. L., Howell, M., Sanddal, N. D., & Berman, A. (2009), Epidemiological and Follow-back Study of Suicides in Alaska, *Circumpolar Health Supplements*, (1), 212-223.

Of the 29 cases, only 4 (13.8%) displayed goodbye behaviors. For instance, informants reported final, atypical behaviors such as meeting with loved ones just prior to the death, texting goodbye to loved ones, and/or apologizing to loved ones.

12.6 Communications of Suicide Ideation

Of the cases studied, 9 (31%) were known to have communicated that they were thinking about dying by suicide. It is reasonable to believe that this may be a conservative estimate, as there may be any number of other family members, friends, or acquaintances who were not interviewed as part of this study but who may have received such a communication. The communications included goodbye texts right before the death, texts communicating suicidal thoughts, increased frequency of calls to loved ones, and communication on social media. Only 1 decedent was known to have called the military crisis line.

12.7 Precipitating Factors

Of the population of individuals who are vulnerable to being suicidal, many lead lives of sustained psychological pain, yet never act on their suicidal thoughts. In many suicides, a triggering event – one final event or set of events – leads that individual to attempt to take his or her life. This is known as a precipitating event. These events, by themselves, are not sufficient to lead a healthy person to end his/her life. However, to a person with vulnerability to suicide (i.e., having significant predisposing risk), the event or set of events triggers the suicide.

A number of precipitating factors or triggering events were seen across the cases studied. In only one case was there no single precipitating factor identified. In 28 cases (96.6%), the decedents were on a downward spiral due to a number of different stressors, such as financial issues, pending job loss or demotion and/or relationship loss. In 11 cases (37.9%), the decedent ended his life immediately after a verbal and/or physical altercation with their significant other.

12.8 Suicide Notes Left

Only 25% to 33% of those who die by suicide leave a suicide note.[20] [21] When left, notes offer a window into the mind of the decedent typically in the hours or days preceding the suicide, when – it is presumed – these notes were written. In this sample of 29 cases, 10 (34.5%) left a suicide note – a proportion comparable to that found across all suicides.

12.9 Significant Loss

SOF members take great pride in their careers and have always seen themselves as the best of the best. When these members face a shameful situation, they may be unable to cope with it. In addition to disciplinary action, leading to loss of face and loss of peer support, the SOF members

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[20] Kohlmeier, R.E., McMahan, C.A., & DiMaio, V.J.M. (2001). Suicide by Firearms: A 15-year Experience. *The American Journal of Forensic Medicine and Pathology 22*(4):337-340, 2001.

[21] Haines, J., Williams, C., & Lester, D. (2011). The Characteristics of Those Who Do and Do Not Leave Suicide Notes: Is the Method of Residuals Valid?. *OMEGA: The Journal of Death and Dying*, 63(1), 79-94.

in this study also experienced loss of a loved one (34.5%), pending job loss or demotion (31%), and financial loss (17.2%).

12.10 Exposure to Suicide

Four decedents (13.8%) had a family history of suicide. A family history of suicide exposes the vulnerable individual to a model that has the potential to influence and impel suicidal behaviors among other family members. Moreover, a family history may describe a genetic or biochemical vulnerability to suicide. Exposure to suicide by others (not only family members) through observation, media reports, or general knowledge or discussion among family or friends, also, has been found to influence and stimulate imitative behavior. In this sample of cases, 16(55.2%) of the decedents talked about suicide by SOF members they knew personally in their Unit. It may be reasonable to assume that all personnel in a unit with a suicide can benefit from counseling, since they have probably been exposed to the many of the same stressors as the decedent and now have an additional stressor of having lost a unit colleague to suicide.

12.11 Past Attempts

The most significant predictor of a future suicide is a past suicide attempt.[22] Results of this study show that only 5 (17.2%) cases studied had attempted suicide at least once in the past. Respondents knew details of the previous attempts for 2 cases. They had used low lethality methods,[23] and one had attempted suicide multiple times. In both cases, the decedent had been taken to the hospital and treated in the Emergency Department or hospitalized. One of the previous attempts occurred approximately two years prior to the suicide and the other occurred approximately eight years prior to the suicide. The respondents did not know if the chain of command or medical personnel were notified about the attempt. Medical records indicate that USSOCOM medical personnel were aware of previous attempts by the individual who made multiple attempts. However, there is no record of suicide attempt by the other attempt survivor.

12.12 Availability of Firearms

In the United States, the method most commonly used by those who die by suicide is a firearm (gunshot wound). As many people die by suicide by use of a firearm as those who die by all other means combined. Firearms are used because they are readily accessible and available (the majority of gunshot wound suicides die at home where a firearm was readily accessible in that home) where the firearm is stored, often loaded and unlocked (Maris et al, 2000).[24] Higher rates of gun ownership are associated with higher rates of gun suicide and, correspondingly, lower

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[22] Runeson et al (2010), Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study, *BMJ,* 341:c3222.

[23] High lethality methods refer to those methods that are generally fatal – e.g. Firearms, Hanging. Low lethality measures refer to those methods that are less likely to result in death – e.g. Cutting the wrist, Poisoning with Tylenol.

[24] Maris, R., Berman, A.L., & Silverman, M.M. (2000). *Comprehensive textbook of suicide*. NY: Guilford Publications.

rates of non-gun suicide.[25] Firearms are owned by an estimated 38% of U.S. households.[26] In this sample, 22 (75.9%) of decedents owned and had access to a personal firearm.

Decedents who use a firearm to bring about his or her death are typically familiar and comfortable with its use. Loved ones were asked about whether the decedent had ready access to a firearm with the necessary ammunition. For the purposes of this study "having access to a firearm" was defined as being able to obtain a firearm and use it to end one's life. Respondents were asked about the kinds of firearms the decedent had access to. Of the decedents, 19(65.5%) owned a handgun, 9(31%) owned a shotgun, 10(34.5%) owned a rifle, and 4(13.8%) owned some other type of gun.

> "There is a very strong culture around always packing a loaded firearm-it was expected that a gun was always present and loaded at close reach if not on the person." – Psychological Autopsy Respondent

All the decedents who owned a firearm used it as their means to end their life. Hence, the decision to die by suicide using a firearm was facilitated by both its ready availability and knowledge that it is a highly lethal means to die by suicide. Also reflected in the suicide risk is the fact that SOF population is majority male, and males are more likely to choose firearms as the means to die by suicide than females.

12.13 Substance Abuse

Substance abuse is a known lifetime and acute risk factor for suicide. Substance abuse is a term that applies to the abuse of alcohol, the use of illicit drugs, or abuse of prescription medications. Of sample cases, 13 (44.8%) were known to have harmful or hazardous drinking habits or alcohol dependence. Three (10.3%) of the decedents were known to use illicit drugs.

Smoking is one of many known lifetime risk factors for suicide.[27] In this study, 18(62.1%) of the decedents were current smokers when they died.

12.14 Physical Illness

For some individuals, physical illness underlies their decision to end their life by suicide. Lung disease, ulcer, and AIDS, for example, have each been seen to be associated with a significantly increased likelihood of suicide attempt, independent of the effects of mental disorders.[28]

This study explored the presence of physical illness in the population studied. Findings indicated that 13(44.8%) of SOF members in this study were seeing a physician for treatment of physical conditions such as HIV, chronic pain, skin infections, and seizures.

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13. Summary of Findings

The aim of this study was to answer four primary questions:

1. Why did these individuals die by suicide?
2. Why did these individuals choose the means for suicide that they did?
3. Why did these individuals choose to die by suicide at this time in their life?
4. What (according to the interviewees) could have been done to prevent these suicides?

The first three questions will be addressed in sequence based on the data reported above. The final question is addressed as part of the Recommendations section of this report.

13.1 Why Suicide?

Individuals studied in this sample of psychological autopsies exhibited the following risk factors for suicide:

- Relationship Issues – Nearly all cases had relationship issues. While relationship issues are a risk factor for suicide, these seemed to be chronic and escalating over years in the cases studied. In a number of cases, the decedents were abusive.
- PTSD – Nearly all cases suffered some form of PTSD or emotional trauma following the first deployment. Informants typically saw changes in the SOF member after the first deployment. The downhill trajectory with compounding relationship issues, financial issues and legal issues occur over many years. The earliest prevention point (at least for SOF members who deploy) may be just before the first deployment to prepare them for what they are about to experience.
- It was reported by many of the loved ones that there was a fear that reporting mental health issues or suicidal ideation could lead to being separated from their unit or singled out for problems.

> "Suicide prevention training was viewed as a check in the box. There was no personal interaction. Online training is not very effective; soldiers just click through all of the online trainings and supervisors simply want to know that the trainings were completed." – Psychological Autopsy Respondent

- Suicide prevention training is seen as a perfunctory task. It is usually online and does not provide any skills. All decedents had taken the training and yet they all also died by suicide. This suggests there is/are problems with the existing training model. There was an identified need to have the training involve someone who has been affected by a suicide attempt and/or death.
- Attitude towards suicidal individuals was mentioned as a barrier to help-seeking in nearly all cases. Individuals felt their careers would be negatively impacted and hence, they convinced their loved ones not to contact unit leaders. SOF members also see the way others who sought help were treated and recognized that most of these individuals left the Service soon after they shared that they had suicidal ideation. It was reported that when an individual says they have suicidal ideation, they are marched to the psychiatric unit and treated like a criminal. There continues to be a strong stigma among members and that contributes to a

fear of expressing mental health concerns and/or suicidal ideation. This phenomena creates a paradox for the SOF member and Unit leadership.

- When a SOF member does something that leads to disciplinary action, the resulting loss of face and loss of peer support is often the trigger event. SOF members take great pride in their careers and have always seen themselves as the best. When these members face a shameful situation, they are unable to cope with it.

> "He often said "The job I love and have committed my whole being to is creating my suicidal condition, but I'd rather die than admit to having trouble and being removed from my unit and my team." – Psychological Autopsy Respondent

13.2 Why Suicide by this Method?

As described in Section 3, the psychological autopsy protocol aimed to ascertain why the individual chose to end his or her life with the method that was used. The following hypotheses are presented based on literature and study findings:

- More than 75% of the SOF suicides in this study were by firearm.
- Familiarity could be a factor in choice of method. Of the decedents in this study, 22 (75.9%) owned personal firearms.
- Consistent with other military suicides, SOF members used their personal firearm rather than a military-issued firearm, even though at least 19 (65.5%) had access to a service weapon. This could be because all the suicides occurred either at the SOF members' residence or in an automobile.
- The second most common method of suicide was asphyxiation due to hanging, 5 (17.2%). None of the SOF members who died using this method owned a personal firearm.

13.3 Why Suicide at This Time?

The individuals studied had a number of risk factors for suicide and few protective factors. Against the backdrop of the risk factors, there are often one or two events that lead an individual decide to end his or her life immediately. These events are called triggers. One common trigger was an event that the decedent perceived as a humiliation, such as a court date or other legal issue.

Findings from this study indicate that relationship issues, financial problems and upcoming humiliation were common factors in many of these individuals' decision to end his life.

14. Limitations

As noted above, this study offers an in-depth understanding of SOF suicides, but, because it lacks a control group or comparative sample of non-suicides, it cannot offer definitive conclusions about these deaths as differentiated from SOF members who did not die by suicide.

Psychological autopsy studies rely heavily on interviews with knowledgeable informants. There remains some degree of variability from case to case in the depth of informants' knowledge, their familiarity with proximal events, and the relative recentness of their observations regarding these decedents. That a number of decedents in this cases studied were without a current significant relationship posed increased difficulty in locating the best possible informants for these individuals. Having multiple informants for each case, at times, would lead to conflicting or discrepant observations that had to be resolved, either by further questions to these informants or by the investigator's best judgment in discussion with the research team. In none of the cases studied were the informants noted to be deliberately providing false information. An explanation was sought when there was discrepancy between informants and were resolved in all instances. For example, when a decedent had a physical illness and this information was known to only one of the family members, there were differences in the interviewees' responses. To clarify this difference, the researcher approached the family member who had knowledge of the illness for an explanation. The family member explained the decedent's wish to not share this health information widely and produced medical records verifying the illness.

Another difficulty with the psychological autopsy process is that the next-of-kin's perceptions of how the decedent behaved leading up to the suicide may be clouded by that event. Thus, the responses from the next-of-kin may instead represent the reasons why the next of kin *thought* the individual committed suicide as a way to justify that outcome. It is possible that these justifications are not representative of what the decedent was experiencing.

In a few cases, key informants were unavailable and interviewees were considered to be sufficiently knowledgeable. Relying on multiple investigators always poses the potential for variability in their interviewing skills and, therefore, findings. To account for this we held monthly teleconferences and gave feedback on the basis of reports submitted to date and we held a mid-course, follow-up training of investigators.

Case identification issues abound and denote the many steps along the way from initial case identification to final sample inclusion. Next of kin sometimes refuse to participate because of the emotional weight of the loss. In cases where significant time had elapsed after the suicide, next of kin had moved on and were reluctant to speak about their experience. This may be mitigated in the future if USSOCOM, as regular procedure, conducts psychological autopsies on all suicides in a routine and timely manner. However, it is critical that only trained interviewers be employed that understand the PA protocols and not done on an ad-hoc basis.

15. Conclusion

Suicides by SOF members are statistically rare yet highly tragic events. Identifying potential means to prevent a significant proportion of these deaths has great benefit to all involved.

This sample of SOF suicides shares much in common with samples of suicides by other Service members. However, much has been learned through this effort that specifically describes SOF member experiences. Notably, the cases studied have a reliable set of identifiable risk markers that occur in combination: escalating relationship issues, resulting financial issues, humiliation, and lack of use of mental health care. Nearly all cases suffered some form of emotional trauma following the first deployment. Informants typically saw changes in the SOF member after the first deployment. The downhill trajectory with compounding relationship issues, financial issues and legal issues occur over many years. The earliest prevention point (at least for SOF members who deploy) may be just before the first deployment to prepare them for what they are about to experience. It was reported by many of the loved ones that there was a fear that reporting mental health issues or suicidal ideation could lead to being separated from their unit or singled out for problems

Suicide prevention training is seen as a check in the box. It is usually online and does not have a skill-building component. All decedents had taken the training and yet they all also died by suicide. This suggests there is/are problems with the existing training model. There was an identified need to have the training involve someone who have been affected by suicide attempt and/or death.

Attitude towards suicidal individuals was mentioned as a barrier to help-seeking in nearly all cases. Individuals felt their careers would be negatively impacted and hence, they convinced their loved ones not to contact the unit leaders. SOF members also see the way others who sought help were treated and recognized that most of these individuals left the Service soon after they shared that they had suicidal ideation. It was reported that when an individual says they have suicidal ideation, they are marched to the psychiatric unit and treated like a criminal. There continues to be a strong stigma among members and that contributes to a fear of expressing mental health and/or suicidal ideation.

When a SOF member's deeds lead to disciplinary action, the resulting loss of face and loss of peer support is often the trigger event. SOF members take great pride in their careers and have always seen themselves as the best. When these members face a shameful situation, they are unable to cope with it.

Suicidal behavior is the end point to a complex pathway involving the coming together of a large number of variables. This includes long-term vulnerability, an absence of organizational protection, an overwhelming of protective factors by the intensity of SOF operational environment, and the press of stressful events that challenge the moral and ethical norms of a peacetime environment. Understanding as much as possible about individuals who get trapped on this pathway and who see no way out other than by way of the most accessible and lethal of means to end their psychological pain is essential to developing interventions. These

interventions could save and make meaningful many lives lived in despair and could save thousands the unbearable social and emotional cost of suicide.

This study is a step in accomplishing that end.

16. Recommendations

Based on the findings of the psychological autopsies conducted, we make the following recommendations:

1. Relationship issues seem to always worsen sharply towards the end. Using this as a red flag may act as an early warning sign. Broaden suicide prevention training to include handling relationship issues.

2. Nearly all SOF members who deploy witness events that are morally traumatic and emotionally stressful. Consider individual or group therapy sessions for all SOF members returning from deployment to help them deal with their experience. Sometimes the stress does not manifest immediately upon return from deployment, so recommend monitoring and ongoing assessment for 6-12 months.

3. Improve suicide prevention training to require in-person events with live, active role playing so that SOF members can experience recognizing warning signs and practice their skills engaging an individual that may by suicidal and knows how to get help. Suicide prevention training should be conducted with someone outside of the Service. Results indicate that SOF members will not respond to someone within their command for this training.

4. Involve families and loved ones in suicide prevention and other such trainings. Again, trainings should be conducted in-person by a person they trust, and preferably not in the command structure. Consider training those who have been affected by suicide (when they are ready to take on such a role) to be suicide prevention trainers.

5. Change attitude towards suicidal individuals. Educate unit leaders on appropriate responses towards a suicidal individual. Unit leaders have probably already been exposed to the usual training about warning signs and risk factors. Rather than have another didactic training, arrange small group discussions where an external organization with suicide prevention expertise can meet with the unit leaders to problem solve and have an open discussion about recognizing and responding to an at-risk individual.

6. When a SOF member is in legal trouble, provide a support mechanism and therapy or counseling to help him/her cope during the legal proceedings.

7. While we conducted psychological autopsies on nearly half of the suicides that occurred between January 2012 and December 2015, it is still a small sample. SOF will gain the most current and relevant information for suicide prevention by making psychological autopsies part of the regular protocol in the aftermath of a suicide. It is also recommended that the psychological autopsies be conducted by researchers external to the military because many informants were concerned about their input reaching military leadership in an identifiable manner. For the older cases, it was difficult to obtain additional information from sources due to length of time since death, difficulty reaching people, and people not willing to talk.

8. The type of missions and the experiences of SOF members are very different from the general military. A surveillance system that collects and analyzes SOF suicides on an annual basis will provide the leads necessary to tailor suicide prevention to the needs of SOF members.

9. As most suicides are by firearms, establish a safe-keeper program to secure the personal weapons of at-risk soldiers.

10. Provide counseling to all personnel in a unit with a suicide, since they have probably been exposed to many of the same stressors as the decedent and now have an additional stressor of having lost a unit colleague to suicide.

11. Suicides were noted to peak every fall. An increased emphasis on watching for risk factors and warning signs for suicide, and encouraging help-seeking during the fall months may help identify those at risk.

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Appendix A.
Logic Model for the USSOCOM Psychological Autopsy Project

Resources	Activities	Outputs	Outcomes
Funding Staff	Develop research plan. Obtain clearance from IRB, OMB.	Developed methodology for prevalence analysis. Developed methodology for psychological analysis.	Research plan with all necessary approvals.
	Conduct outreach and knowledge transfer.	Developed communications plan for effective project management. Conducted training for researchers.	Completed Psychological Autopsies.
	Conduct prevalence analysis.	Obtained better understanding of the scope and epidemiology of the problem.	Established baseline numbers, of SOF suicides for evaluating possible interventions.
	Conduct psychological autopsies.	Obtained better understanding of the events leading to SOF suicides. Provided recommendations to continue obtaining data about numbers and characteristics of SOF suicides.	Created knowledgebase for developing SOF suicide prevention programs. Developed a system to monitor trends in SOF suicides.

Impact: Reduction in numbers of SOF suicides.

Appendix B.
Protocol for Psychological Autopsy Study

American Association of Suicidology Semi-Structured Interview for Psychological Autopsy-*Adapted for United States Special Operations Command*

Note: The interviewer will **NOT** be asking these questions verbatim. Interviewers will be trained to conduct the interview in a manner that is sensitive, professional, and adapted to the specific interviewee.

PLEASE NOTE THE ROLE(S) AND DEMOGRAPHIC INFORMATION FOR THE RESPONDENT(S) ON THE COVER SHEET.

I. Demographic Information Decedent	
1. Date and time of death	Date: Time:
2. Location of death (city, state, country)	
3. Home town (city, state, country)	
a. If not US-born, age at which decedent moved to the US	Age:
4. Race/Ethnicity	__ White __ Black __ Hispanic __ American Indian/ Alaskan Native __ Asian __ Pacific Islander __ Other, *specify*: _____ __ Don't know
5. How much did the decedent identify his/her racial/ethnic/cultural heritage?	Strong 5 4 3 2 1 Weak *Please explain:*
6. Gender	__ Male __ Female
7. Marital status	__ Single, never married __ Divorced *(# years:)*

	__ Single, in a long-term relationship, engaged __ Married *(# years:)* __ Separated/Separating *(# months:)* __ Widowed *(# years:)*
7a. If married, did h/she reside with spouse?	__ Yes __ No, *specify*
8. Number of years of schooling	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20+ __ Don't know
9. Where did h/she live at the time of death?	__ Barracks, tents __ Bachelor Enlisted Quarters __ On-Base Family Housing __ Don't Know __ Owned/leased off-base housing __ Ship __ Other, *specify*
10. Did h/she have any children?	__ Yes, *how many, ages* __ No __ Don't Know
10a. If they had children, did the children live with them?	__ Yes __ No, *where and with whom did the children live*
11. Raised by	__ Biological parents __ Adoptive parents __ Foster parents __ Other relatives, *specify*: __ Other, *specify*: __ Don't know

II. Participation in Organized Religion		
12. Did (s)he identify or affiliate with a specific religion?	__ Yes __ No	If yes, *which religion*?
13. Did (s)he consider self to be a spiritual person?	__ Yes __ No	
14. Attended religious services	__ Daily __ Weekly __ Once or twice a month __ Monthly	__ Rarely __ Don't know __ Never
15. Changed level of participation in religious activities over past year	__ Increase __ Decrease	__ Remained the same __ Don't know
16. Does your family or did the decedent have any religious beliefs regarding death by suicide? For example, is there anything in your or his/her religious beliefs that may have caused him/her to be hesitant about attempting suicide?	__ Yes __ No	If yes, *please specify*:

III. USSOCOM Duty Status

17. When did he/she join the military? 17a When did he/she join USSOCOM?		
18. Where were they stationed at time of death? (Base, City, State, Country)		
19. How long was the decedent with their most recent unit?		
20. What was duty status prior to death? *Please explain further if any are checked and specify the number of weeks prior to death*	__ Active Component __ Reserve Component on Active Duty	__ Retired __ Released from Active Duty within 120 days __ Other __ Demotion/Assignment in question because of performance __ Does not apply
20a. What was their duty environment like at time of death, i.e. were they on leave, in training, etc.	__ With Permanent Command __ On Leave __ Awol __ Temporary Duty Assignment __ Deployed	__ In Training __ Psychiatric Hospitalization __ Medical Hold __ In evacuation chain __ Correctional Facility __ Other (*specify*) __ Don't Know
21. General satisfaction with USSOCOM life/work?	__ Happy __ Unhappy __ Neither	__ No strong feelings __ Don't know

22. How connected did the decedent feel to USSOCOM? For example, were they involved in USSOCOM community and events?	__ Very Connected __ Moderately Connected __ Somewhat Connected __ Not Connected
23. Had the feeling of connection changed in any way in the last six months?	__ No __ Yes, if yes, *please describe*:
24. a. Had the decedent been deployed overseas?	__ No __ Yes, if yes, how many total Deployments? _____

	Most recent Deployment	Next most recent	Next most recent	Next most recent
Dates Deployed				
Location				
In combat?				

b. If in combat, the decedent (check all that apply):

__ Was under enemy fire
__ Shot weapon
__ Killed someone: enemy/ civilian/ friendly fire accident
__ Saw dead or injured body(ies)
__ Handled or uncovered dead body(ies)

c. If there was deployment(s) in combat, were injuries sustained?	__ No __ Yes, describe injury and any limitations of activities of daily living or implications for promotion:
25. Did the decedent have any upcoming deployments?	__ Yes, *specify where, when* __ No

IV. Financial Status

26. Financial situation of decedent	__ No financial pressure __ Significant debt __ Lived paycheck to paycheck __ Don't know __ Other, *specify*:
27. What was the decedent's pay grade/rank within USSOCOM?	
28. Any recent change or threats to financial stability of decedent?	__ Yes, *explain*: __ No

V. Buffers/Connectedness

29. Referred to counseling/psychotherapy in the last 12 months?	__ Yes __ No __ Don't know
30. If referred, attended counseling/therapy in the last 12 months?	__ Yes. *From whom (name of provider)?* __ Outpatient? __ Inpatient? __ No __ Don't know
31. In therapy at the time of death?	__ Yes __ N/A __ No – *stopped when?* __ Don't know

32. If in treatment at time of death, how often was the decedent suppose to attend sessions?	
33. If in treatment at time of death, adherence to recommended schedule of sessions?	__ Yes __ Sometimes, e.g., inconsistent attendance __ No __ Don't know

34. Barriers to receiving mental health care if needed	__ Yes __ No __ Don't know	If yes, *why*? __ Didn't believe in counseling or seeking help __ Difficulty finding or getting into a facility __ Difficulty finding or getting treatment __ Problems getting help at home __ Problems paying bills __ Problems with transportation __ No insurance coverage __ Did not want help __ Other, *specify*: __ Don't know
35. Saw Chaplain before his/her death?	__ Yes, within __7 days __30 days __12 months If yes, *general frequency of contact* (e.g., twice a week, once a week) __ No __ Don't know	
36. Did h/she meet with the Family Advocacy Program prior to death?	__ Yes, within __7 days __30 days __12 months If yes, *general frequency of contact* (e.g., twice a week, once a week) __ No __ Don't know	

36a. What was the reason for attending this program?				
	Yes	No	Don't Know	Comments
37. (S)he felt that there were people who would listen and understand when (s)he needed to talk				
38. In a crisis, (s)he felt the support needed from family or friends				
39. When needed help right away, (s)he knew people (s)he could count on				
40. (S)he felt that (s)he had more than one friend				
41. (S)he was happy with his/her friendships				
42. (S)he had people with whom (s)he could do enjoyable things				
43. (S)he felt (s)he belonged in the USSOCOM community				
44. Enjoyed being in particular command/unit				
45. Felt supported by chain of command				

VI. Significant Relationships/Sexuality

46. Was decedent in a significant relationship at time of death?	__ Yes __ No	If yes, *duration of this relationship*

	__ Don't know	
a. Was this relationship on the verge of breaking up or threatened with breaking up?	__Yes; if yes, *how recently*: __ No __ Don't know	If yes, *any known triggering event*?
b. Had this relationship recently undergone a break-up or separation?	__ Yes; if yes, *how long prior to the death*? __ No __ Don't know	
c. Was anyone in this relationship pregnant or did anyone have a recent abortion?	__ Yes, *specify*: __ No __ Don't know	If yes, *how recently:*
47. If not in a relationship at the time of death, when was the last significant relationship and its duration?	Number of days/weeks/months prior to death _____ *Specify why relationship ended*:	
48. Was the decedent known to be lesbian, straight, bi-sexual, transgender, or questioning (LGBTQ)?	__ Straight __ LGBTQ (*specify*)	
49. If LGBTQ	a. Decedent's self-acceptance of sexual orientation: b. Was decedent "out of the closet"? c. Decedent's perceived acceptance by family	__ Accepting __ Struggling with __ Yes __ No __ Felt accepted __ Felt rejected

		__ Other, *specify*:
	d. Decedent's perceived acceptance by peers?	__ Felt accepted __ Felt rejected __ Other , *specify*:
	e. Had the decedent been harassed, discriminated against, or bullied because of his/her sexual orientation?	__ Yes (*describe* any incidents, especially their temporal relationship to the death) __ No

VII. Possible Clustering

50. Did the decedent know any USSOCOM members who died by suicide in the last year?	__ Yes __ No __ Don't know	If yes, *name(s) of decedent(s)* If yes, *specify relationship* to decedent, e.g., friend, acquaintance:
51. If yes, did the decedent show excessive interest in any prior decedent, seem preoccupied by this death, or otherwise excessively affected by this death?	__ Yes __ No __ Don't know	If yes, *whom and what were observed*?

VIII. Suicide Risk

		30 days	7 days
52. Did the decedent complain of, talk about, disclose, or describe or appear to experience any of these symptoms or behaviors ***in last 30 or 7 days*** preceding death (*check all that apply*) (IS PATH WARM)	**I**deation (communicated thoughts of suicide)		
	Substance Use (increased or excessive)		
	Purposelessness; no reason for living		
	Anxiety, agitation, unable to sleep or sleeping all the time		
	Feeling **T**rapped – like there's no way out		
	Hopelessness		
	Withdrawal/Social isolation		
	Anger/Rage/Expressions of wanting revenge		
	Recklessness/excessive risk-taking		
	Mood changes		
53. Did the decedent complain of, talk about, disclose, or describe or appear to experience any of these symptoms or behaviors ***in last 30 or 7 days*** preceding death (*check all that apply*)		30 days	7 days
	Appeared to have made a change for the better		
	Behaved Impulsively		
	Displayed uncontrolled rage or aggressive behavior		
	Demonstrated constricted thinking or "tunnel vision"		
	Appeared confused, disoriented, or psychotic		
	Expressed feelings of helplessness		
	Was irritable		
	Was unmotivated		
	Described feelings of being intolerably alone		

	Showed an inflated sense of self or acted excessively in any way (*describe*)		
	Appeared to prepare for own death (e.g. giving things away, making references to being gone in near future)		
	Expressed wish to reunite with someone deceased or to be reborn		
	Expressed feelings of being a burden to others		
	Had flashbacks		
	Avoided places and people		
54. Were any of these symptoms or complaints more chronic, i.e. present for more than 30 days? If so, please specify:			

55. Mental status: Did decedent exhibit any of these in the last 30 or 7 days of life?		30 days	7 days
	Poor comprehension		
	Poor judgment		
	Hallucinations or delusions (*specify*)		
	Difficulty recognizing friends or family members		
56. Precipitants to death (Check all that apply and specify)	__ Significant loss(es) – relationships, job, finances, prestige, self-concept, family member, moving, anything else important to deceased individual (*specify all*:_____) __ Disruption of a primary relationship (real or perceived) __ Legal troubles __ Difficulties with police __ Recent traumatic event __ Significant life changes (negative as well as positive): Relationships/break-ups/ issues at home? __ Suicide or suicide attempt by family member, loved one, friend, or fellow USSOCOM member __ Anniversary of a significant loss __ Exposure to suicide of another (e.g. celebrity) through media or personal acquaintance __ Recent discharge from psychiatric institution or care? Any other stressors? _____		

57. Were there any issues in civilian home life that may have caused the decedent emotional distress?	If so, *specify*:
58. Were there any issues in USSOCOM life that may have caused emotional distress?	If so, *specify*:
59. What was the decedent's typical way of coping with stressful events?	*Describe*:
60. Had the decedent received their suicide prevention training?	__ Yes, *when was their last training prior to death* __ No __ Don't Know
61. Montgomery Asberg Depression Rating Scale	1 - **APPARENT SADNESS** In the last 30 days of life, did _____ appear sad (being despondent, gloomy, and despairing; more than just ordinary short-term low spirits) as reflected in speech, facial expression, and posture? Rate by depth and inability to brighten up. 0 No sadness. 2 Looked dispirited but did brighten up without difficulty. 4 Appeared sad and unhappy most of the time. 6 Looked miserable all the time. Extremely despondent.

	2 - **REPORTED SADNESS** In the last 30 days of life, how often did _____ express being depressed (being in low spirits, despondent or had feeling of being beyond help and without hope), regardless of whether it was reflected in appearance or not? Rate according to intensity, duration and the extent to which the mood was reported to be influenced by events. 0 Occasional sadness in keeping with the circumstance 2 Sad or low but brighten up without difficulty. 4 Pervasive feelings of sadness or gloominess. The mood was still influenced by external circumstances. 6 Continuous or unvarying sadness, misery or despondency. 3 - **INNER TENSION** In the last 30 days of life, did _____ experience any feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread or anguish? Rate according to intensity, frequency, duration and the extent of reassurance called for.

	0 Calm. Only fleeting inner tension. 2 Occasional feelings of edginess and ill-defined discomfort. 4 Continuous feelings of inner tension or intermittent panic which (s)he can only master with some difficulty. 6 Unrelenting dread or anguish. Overwhelming panic. 4 - **REDUCED SLEEP** In the last 30 days of life, did _____ experience reduced duration or depth of sleep compared to his/her normal pattern normal pattern? 0 Slept as usual. 2 Had slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep. 4 Sleep reduced or broken by at least two hours. 6 Less than two or three hours sleep per night. 5 - **REDUCED APPETITE** In the last 30 days of life, did _____ lose appetite? Rate by loss of desire for food or the need to force oneself to eat. 0 Normal or increased appetite.

	2 Slightly reduced appetite. 4 No appetite. Food was tasteless. 6 Needed persuasion to eat at all. 6 - **CONCENTRATION DIFFICULTIES** In the last 30 days of life, did _____ have difficulties in collecting his/her thoughts that mounted to the inability of concentrate? Rate according to intensity, frequency, and degree of incapacity produced. 0 No difficulties in concentrating. 2 Occasional difficulties in collecting one's thoughts. 4 Difficulties in concentrating and sustaining thought which reduced ability to read or hold a conversation. 6 Unable to read or converse without great difficulty. 7 - **LASSITUDE** In the last 30 days of life, did _____ experience difficulty getting started or slowness initiating and performing everyday activities? 0 Hardly any difficulties in getting started. No sluggishness. 2 Difficulties in starting activities.

	4 Difficulties in starting simple routine activities, which were carried out with effort. 6 Complete sluggishness. Unable to do anything without help. 8 - **INABILITY TO FEEL** In the last 30 days of life, did _____ experience a reduced interest in the surroundings or activities that normally give pleasure? Or was his/her ability to react with adequate emotion to circumstances or people reduced? 0 Normal interest in the surroundings and in other people. 2 Reduced ability to enjoy usual interests. 4 Loss of interest in the surroundings. Loss of feelings for friends and acquaintances. 6 The experience of being emotionally paralyzed, unable to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends. 9 - **PESSIMISTIC THOUGHTS** In the last 30 days of life, did _____ have any thoughts of guilt, inferiority, self-blame, sinfulness, remorse and ruin? 0 No pessimistic thoughts. 2 Fluctuating ideas of failure, self-blame or self-depreciation.

	4 Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future. 6 Delusions of ruin, remorse and unredeemable sin. Self-accusations which are absurd and unshakable. 10 - **SUICIDAL THOUGHTS** In the last 30 days of life, did _____ feel that life was not worth living, expressed that a natural death would be welcome, had suicidal thoughts, or mentioned preparations for suicide? (Suicidal attempts should not in themselves influence the rating.) 0 Enjoyed life or took it as it came. 2 Was weary of life. Only fleeting suicidal thoughts. 4 Stated that they were probably better off dead. Suicidal thoughts were common, and suicide was considered as a possible solution, but without specific plans or intention. 6 Made explicit plans for suicide when there was an opportunity. Active preparations for suicide.
62. Hamilton Anxiety Rating Scale	Rate the decedent by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions. 0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

	1. In the last 30 days of life, was _____ anxious (had worries, anticipation of the worst, fearful anticipation, irritability)? 0 1 2 3 4 2. In the last 30 days of life, was _____ tense (had feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, unable to relax)? 0 1 2 3 4 3. In the last 30 days of life, was _____ fearful (of dark, of strangers, of being left alone, of animals, of traffic, of crowds)? 0 1 2 3 4 4. In the last 30 days of life, did _____ have insomnia (difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors)? 0 1 2 3 4

	5. In the last 30 days of life, did _____ experience any impairment intellectually (difficulty in concentration, poor memory)? 0 1 2 3 4 6. In the last 30 days of life, was _____ depressed (experienced loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing)? 0 1 2 3 4 7. In the last 30 days of life, did _____ have any muscular symptoms (pains and aches, twitching, stiffness, jerkiness, grinding of teeth, unsteady voice, increased muscular tone)? 0 1 2 3 4 8. In the last 30 days of life, did _____ experience any sensory problems/ symptoms (ringing in ears, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation)? 0 1 2 3 4

	9. In the last 30 days of life, did _____ have any cardiovascular symptoms (rapid heart beat, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat)? 0 1 2 3 4 10. In the last 30 days of life, did _____ have any respiratory symptoms (pressure or constriction in chest, choking feelings, sighing, shortness of breath)? 0 1 2 3 4 11. In the last 30 days of life, did _____ show any gastrointestinal symptoms (difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, rumbling noise from movements in the intestines, looseness of bowels, loss of weight, constipation)? 0 1 2 3 4 12. In the last 30 days of life, did _____ exhibit any genitourinary symptoms (frequency of urination, urgency of urination, absence of a menstrual period, abnormally heavy and prolonged menstrual period, development of frigidity, premature ejaculation, loss of libido, impotence)? 0 1 2 3 4

	13. In the last 30 days of life, did _____ show any autonomic symptoms (dry mouth, flushing, paleness, tendency to sweat, giddiness, tension headache, raising of hair) 0 1 2 3 4 14. In the last 30 days of life, did _____ exhibit other signs of nervousness/ tension? (fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor [face was pale], swallowing, etc.)? 0 1 2 3 4

IX. Physical Health

63. Any major physical health problems during his/her life prior to joining the military that required hospitalization?	__ Yes, *specify*: __ No __ Don't know
64. Was the decedent seeing a doctor for any illnesses in the 6 months prior to death?	__ Yes, *specify*: __ No __ Don't know
65. Did the health problem change his/her lifestyle?	__ Yes, *specify which illness and how*: __ No __ Don't know
66. Did the health problem interfere with daily functioning or opportunities for promotion?	__ Yes, *specify which illness and how*: __ No __ Don't know

X. Emotional Reactivity/Aggression/Trouble with Authority

67. Over the course of his/her life, and particularly in recent days, how often did decedent:	Frequently	Last 30 days	Last 7 days
a. Throw a temper tantrum – screaming, slamming doors, etc.			
b. Get into a physical fight with someone			
c. Get into frequent intense verbal arguments with someone			
d. Deliberately hit another person or animal			
e. Engage in behaviors that led to reprimands, disciplinary action, etc.			

f. Have difficulties with civilian or military police that resulted in a warning, arrest, or conviction for a misdemeanor or felony?			
g. Do something that caused someone else to complain to civilian or military police or to other family members?			

XI. Lifestyle/Character

68. Would you describe the decedent as a perfectionist?	__ Yes __ No __ Don't know				
69. Was the decedent preoccupied with and distressed by an imagined defect in appearance or body part?	*Describe*:				
70. Would you describe the decedent's usual behavior as rigid or very strict?	__ Yes __ No __ Don't know				
71. As a general pattern of behavior, did the decedent engage in any of the following behaviors?	Never	Sometimes	Frequently	Always	Behavior become MORE risky in recent months
72. Drove faster than 10 miles over speed limit					
73. Wore seat belt					
74. Smoked cigarettes or cigars					
75. Rode a motorcycle (or all-terrain vehicle (ATV) or snowmobile)					

76. Used a helmet while riding a motorcycle (or ATV, snowmobile)					
77. Drove when (s)he had been drinking alcohol?					
78. Gambled?					
79. Chewed Tobacco					

Details on certain risk-related behaviors:	
80. Duration of smoking behavior	__ 0-4 years __ 5-9 years __ 10-14 years __ 15 years or more __ Don't know
81. Was decedent trying to quit smoking at time of death?	__ Yes __ No __ Don't know
82. a. Any motor vehicle accidents in year prior to decedent's death? b. Did decedent ever crash while riding a motorcycle (ATV, or snow mobile)?	__ Yes, *describe each*: __ No __ Yes, *specify when, how many times*: __ No __ Don't know
83. Would you describe the decedent as impulsive?	__ Yes __ No

	__ Don't know
84. Were there any financial problems related to gambling?	__ Never __ Sometimes __ Often __ Don't know

XII. Suicidal Capability

XIIa. Psychiatric and Traumatic History

85. Was the decedent ever diagnosed with a mental illness?	__ Yes, *diagnosis, when* __ No __ Don't know
86. Hospitalization in psychiatric setting	__ Yes, *describe where, when, diagnosis* **(and request release for records)** __ No __ Don't know
87. Did s/he intentionally harm his/her body in a socially unacceptable way and with little to no risk to life, for example, by cutting or burning him/herself? If so, specify what and frequency, if known.	__ Yes, *describe (Type: cutting, burning, etc.; frequency)* __ No __ Don't know
88. History of physical or sexual abuse	__ Yes, if yes, *specify*: __ No __ Don't know
89. History of other victimization	__ Yes, if yes, *specify*: __ No __ Don't know

XIIb. Suicide Attempt History

90. Approx. Date of	Method	Did the attempt require medical	What appeared to have	Did the decedent enter counseling after the attempt	If yes, was this perceived as helpful?

attempt (mo./yr.)		intervention/hospitalization? If yes, *describe*:	triggered the attempt?	and/or was s/he prescribed new medication? (*please specify*)	

XIIc. Suicide Ideation

			Ever?	In the last year?	In the last 30 days
91. Did the decedent express thoughts about death, dying, suicide?	__Yes __ No __ Don't know	If yes, *describe (specific thoughts, etc.; frequency)*			
92. Did the decedent talk about a desire wish to "be dead" or to "sleep forever"?	__Yes __ No __ Don't know	If yes, describe *(specific thoughts, etc.; frequency)*			
93. Did the decedent threaten suicide or have intent to die?	__Yes __ No __ Don't know	If yes, *describe (specific thoughts, etc.; frequency; and to whom threat was made)*			

94. Did the decedent disclose a plan to die by suicide?	__Yes __ No __ Don't know	If yes, *describe (specific thoughts, etc.; frequency; and to whom plan was disclosed)*			
95. Did the decedent prepare for or rehearse suicide attempt?	__Yes __ No __ Don't know	If yes, *describe (specific thoughts, etc.; frequency)*			
96. Did the decedent ever have any discussion with you on more of an intellectual level about suicide and/or express their attitudes toward suicide?	__Yes __ No	If yes, *describe (specific thoughts, etc.; frequency)*			

IF suicidal thoughts were expressed at any time, please specify what was said/written and code these as Active ("e.g. I want to kill myself") or Passive ("I wish I were dead").

XIId. Substance Abuse

97. The Alcohol Use Disorders Identification Test: Interview Version	(Read questions as written and record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about _____'s use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Circle the correct answer number.) 1. How often did _____ have a drink containing alcohol? (0) Never (skip to Questions 9 and10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week 2. How many drinks containing alcohol did (s)he have on a typical day when drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more 3. How often did the decedent have six or more drinks on one occasion? (0) Never (1) Less than monthly

	(2) Monthly (3) Weekly (4) Daily or almost daily *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0 4. How often during the 12 months before _____'s death was (s)he not able to stop drinking once (s)he had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily 5. How often during the 12 months before _____'s death did (s)he fail to do what was normally expected of him/her because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily 6. How often during the 12 months before _____'s death did (s)he need a first drink in the morning to get going after a heavy drinking session? (0) Never

	(1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily 7. How often during the 12 months before _____'s death did the (s)he have a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily 8. How often during the 12 months before _____'s death was (s)he unable to remember what happened the night before because (s)he had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily 9. Was _____ or someone else ever been injured as a result of his/her drinking? (0) No (2) Yes but not in the last year

	(4) Yes during the last year 10. Had a relative or friend or a doctor or another health worker been concerned about - _____'s drinking or suggested (s)he cut down? (0) No (2) Yes but not in the last year (4) Yes during the last year **Add total score here: _____**
98. DUDIT – Drug Use Disorders Identification Test	1. How often did _____ use drugs other than alcohol? (See list of drugs in Appendix A) __ Never __ Once a month or less often __ 2-4 times a month __ 2-3 times a week __ 4 times a week or more often 2. Did _____ use more than one type of drug on the same occasion? __ Never __ Once a month or less often __ 2-4 times a month __ 2-3 times a week

	__ 4 times a week or more often 3. How many times did _____ take drugs on a typical day when (s)he used drugs? __ 0 __ 1-2 __ 3-4 __ 5-6 __ 7 or more 4. How often was _____ influenced heavily by drugs? __ Never __ Less often than once a month __ Every month __ Every week __ Daily or almost every day 5. During the 12 months before _____'s death, did (s)he feel that her/his longing for drugs was so strong that (s)he could not resist it? __ Never __ Less often than once a month __ Every month __ Every week __ Daily or almost every day

	6. Has it happened, during the 12 months before _____'s death, that (s)he had not been able to stop taking drugs once (s)he started? __ Never __ Less often than once a month __ Every month __ Every week __ Daily or almost every day 7. How often during the 12 months before _____'s death had the (s)he taken drugs and then neglected to do something (s)he should have done? __ Never __ Less often than once a month __ Every month __ Every week __ Daily or almost every day 8. How often during the 12 months before _____'s death had (s)he needed to take a drug the morning after heavy drug use the day before? __ Never __ Less often than once a month __ Every month __ Every week __ Daily or almost every day

	9. How often during the 12 months before _____'s death had (s)he had guilt feelings or a bad conscience because (s)he used drugs? __ Never __ Less often than once a month __ Every month __ Every week __ Daily or almost every day 10. Had _____ or anyone else been hurt (mentally or physically) because the decedent used drugs? __ No __ Yes, but not over the past year __ Yes, over the past year 11. Had a relative or a friend, a doctor or a nurse, or anyone else, been worried about - _____'s drug use or said to him/her that (s)he should stop using drugs? __ No __ Yes, but not over the past year __ Yes, over the past year
99. History of drinking problem	__ Yes __ No __ Don't know
100. Was the decedent making an attempt at sobriety at the time of death?	*Describe:* (e.g., sober, relapsing, struggling, going to meetings, not attending meetings)
101. History of "accidental overdose"	__ Yes, *specify when, which drug(s), how often (specify for each drug used):*

	__ No __ Don't know
102. History of getting in trouble due to drinking or drug abuse	__ Yes, *specify when, which drug(s), how often (specify for each drug used):* __ What kind of trouble? __ No __ Don't know
103. Had the decedent attended any substance abuse counseling prior to death?	__ Yes, within __7 days __30 days __12 months If yes, *general frequency of contact* (e.g., twice a week, once a week) __ No __ Don't know
104. Under influence of alcohol or other drug at time of death	__ Yes, *specify which drug(s):* __ No __ Don't know

XIII. Family History

105. Had any of the decedents close family members or relatives died and in what manner?								
Role/Relation	Year	Natural	Unintentional	Suicide	Homicide	Undetermined	Other	Don't Know
106. Family history of suicide attempts			__ Yes, *specify* how many, relationship, method			__ No __ Don't Know		

107. Family history of mental illness	__ Yes – *Specify* who, diagnosis If yes, hospitalized?	__ No __ Don't Know __ Yes __ No
108. Family history of substance abuse	Did a parent or sibling or other significant relative have a history of substance abuse/current substance abuse? If yes, *specify* who, what kind of abuse, whether past or current, etc.	If yes, was there any known history of abuse (physical or sexual) by the parent of this decedent?

XIV. Firearm History

109. Did the decedent have access to a service weapon?	__ Yes __ No __ Don't know
110. Was decedent's access to weapons ever restricted?	__ Yes, if yes, *describe the situation*: __ No
111. Did decedent own other firearms? *If yes, specify*:	__ Handgun __ Shotgun __ Rifle

	__ Other, *specify*: __ Don't know
112. If applicable, were the guns kept locked up at home?	__ Yes, if yes, *which firearms* __ No __ Don't know
113. Did the firearms at home have a locking mechanism such as a trigger lock?	__ Yes, if yes, *which firearms* __ No __ Don't know
114. Did the decedent ever handle his/her gun(s) recklessly?	__ Yes, if yes, *which firearms* __ No __ Don't know
115. a. Did the decedent ever play "Russian Roulette?"	__ Yes, if yes, *which firearms* __ No __ Don't know
If death was by firearm, b. Which gun was used?	__ Service weapon __ Other firearm, *which firearm*
c. Was/ did <u>this</u> gun	__ Locked up at home? __ Have a locking mechanism that was kept <u>on</u>?

XV. Suicidal Intent

XVa. Method of death

116. What means did the decedent use to end their life?	__ Firearm – military issue __ Firearm – not military issue __ Hanging/Asphyxiation, if yes, *what was used*_____ __ Drugs, *specify which* __ Gas or Vapor Poisoning, if yes, *specify*_____ __ Fire or steam, if yes, *specify*_____ __ Struck by moving object __ Sharp or blunt object, *specify* _____ __ Other, *specify*_____ __ Don't Know
117. Would decedent have had knowledge and/or capability of assessing the degree of lethality given the method used?	__ Yes __ No __ Don't know
118. Where did the death occur?	__ Residence or barracks, *specify* __ Residence of a friend or family, *specify whom* __ Automobile, away from residence __ Work/Jobsite

	__ Other, *specify* __ Don't Know
119. Were there any witnesses to the death? 119a. If there were witnesses, did the decedent give others a chance to intervene?	__ Yes, *if yes how many, whom (names if possible)* __ No __ Don't Know __ Yes, *specify how*: __ No __ Don't know
120. Was there evidence for prior rehearsal of the suicide or plans? If so, what evidence?	__ Yes, *specify*: __ No __ Don't know
121. Did decedent communicate their intent to die by suicide and/or plan? Includes messages on Facebook, Myspace, e-mail, text, IM, etc.	__ Yes, *specify* and define the time message(s) were sent relative to the time of death: __ No __ Don't know
122. Did decedent leave a suicide note? Includes on Facebook, MySpace, via e-mail, text, etc. **(If note(s) were left, transcribe content)**	__ Yes, *specify*: __ No __ Don't know
123. Do you know if the decedent ever called the National Suicide Prevention Lifeline, Veteran Crisisline, or a similar crisis line?	__ Yes, *how recent to death*? __ No __ Don't know

XVb. Access to Prescribed Medications

124. Had any medications been prescribed for the decedent?	If so, medication	Dosage	Reason for	Compliance (took as prescribed; occasionally missed doses; frequently missed doses; stopped; don't know)	If stopped taking medication, how long ago?

XV. Electronic media

125. a. Did the decedent frequent social networking websites like Facebook, Twitter, MySpace, AIM, Chat?	__ Yes, *specify*: __ No __ Don't know
b. Did you know if they posted on these sites the weeks before they died?	__ Yes, *specify what type of posts and what site* __ No __ Don't know

c. Did the decedent give any indication via these media that they seemed distressed or were contemplating hurting themselves?	__ Yes, *specify*: __ No __ Don't know
126. Did the decedent post anything on his/her site about major events prior to death (disappointments, break-ups, peer issues, getting in trouble, looming deadlines, major upcoming changes, etc.)?	__ Yes, *specify*: __ No __ Don't know
127. a. Did you see any posts on his/her Facebook or MySpace or get any IMs or text messages from him/her that seemed different than usual?	__ Yes, *specify*: __ No __ Don't know
b. Did (s)he write anything that seemed very dark or hopeless?	__ Yes, *specify*: __ No __ Don't know
c. Did (s)he write anything about death or wanting to die?	__ Yes, *specify*: __ No __ Don't know

128. Did the decedent ask for help via these websites, or via e-mail, text, or chat?	__ Yes, *specify*: __ No __ Don't know
129. Did the decedent post any messages that said or seemed to say goodbye or that (s)he was leaving for awhile?	__ Yes, *specify*: __ No __ Don't know

NOTE: Ask if the decedent's computer and email has been kept and is accessible and, if the decedent's emails in the last 7 days of life are available?	36. If yes, download and print. If no, ask if these had been looked at by a family member or other person and, if so, whether there was any content of significance.

XVI. Avocational Interests

130. Typically, what did the decedent do during his/her free time?	
131. a. Was the decedent into any music/bands with morbid messages? b. Was the decent into any music/bands with suicide content?	__ Yes, *specify*: __ No __ Don't know __ Yes, *specify*: __ No __ Don't know

132. Did the decedent have any hobbies, interests, or other activities? If so, specify.	__ Yes, *specify*: __ No __ Don't know
133. Was the decedent reading any particular book at the time of death?	__ Yes, *specify:* __ No __ Don't know
134. Had the decedent recently viewed a movie or television broadcast with suicidal content?	__ Yes, *specify*: __ No __ Don't know
135. Did the decedent spend an inordinate amount of time playing video games?	__ Yes, *specify, include frequency*: __ No __ Don't know
136. Did the decedent seem to favor violent video games?	__ Yes, *specify*: __ No __ Don't know

XVII. Recent Timeline

137. List significant observations from the decedent's life in the following timeframes:

Day	**Events**
Day of death	
Previous day	
2 days before	
3 days before	
4 days before	
5 days before	
6 days before	
7 days before	
Up to 2 weeks before	

138. **Summary** – Ask each respondent to tell you, in his/her own words, why (s)he thought the suicide death occurred and summarize those responses here:

XVIII. Case Summary (by PAI)

In this section, please summarize the key aspects of the case. Please include basic demographic details about the person, anything significant in his/her past, what was going on around the time of death, and why (s)he may have chosen to die at the time that (s)he did using the specific method. Please answer the following questions (using as much space as you need):

I. Basic demographics and overview of the case

II. Summary of chronic and acute risk factors

III. Summary of protective factors present

(1) Why did these protective factors fail?

IV. Events and circumstances leading up to the time of death

V. Conclusion

(1) Why suicide?

(2) Why at this time?

(3) Why by this method?

(4) How do you think the suicide could have been prevented?

XIX. Process Notes (take the space you need in order to answer the questions)

Tell us about who was interviewed and why? Was there someone who was initially not willing to be interviewed but changed his/her mind? Did one parent schedule the interview so the other would not know about his/her participation in the study? Is there anything that will help us to more fully understand the story or the context of the responses in this case? Did one person set up all the interviews? Did one person restrict your access in any way to another potential respondent? If so, why?

If nothing of note, indicate that this is not applicable, N/A.

1. Assessment of the mental state of the **respondent**:
    a. Did the subject appear to be sad?

    b. Did the subject seem to be a danger to themselves or others?

    c. (2a) If so, please specify observations.

    d. Were any interventions needed?

    e. Were any referrals made to care providers, 800-number, Military Crisis line, TAPS, support groups, or other services?

2. Respondents' general attitude toward the interview? Cooperative? Defensive?

3. Any discrepancies in reporting and/or any doubts regarding the validity of this person's responses, etc.:

4. Appendix A – List of Drugs (Note! Not Alcohol!)

Cannabis	Amphetamines	Cocaine	Opiates	Hallucinogens	Solvents/inhalants	GHB and others
Marijuana	Methamphetamine	Crack	Smoked heroin	Ecstasy	Thinner	GHB
Hash	Phenmetraline	Freebase	Heroin	LSD (Lisergic acid)	Trichlorethylene	Anabolic steroids
Hash oil	Khat	Coca leaves	Opium	Mescaline	Gasoline/petrol	Laughing gas (Halothane)
	Betel nut			Peyote	Gas	
	Ritaline (Methylphenidate)			PCP, angel dust (Phencyclidine)	Solution	Amyl nitrate (Poppers)
				Psilocybin	Glue	Anticholinergic compounds
				DMT (Dimethyltryptamine)		

PILLS – MEDICINES

Pills count as drugs when the decedent took
- more of them or take them more often than the doctor has prescribed for the decedent
- pills because the decedent wanted to have fun, feel good, get "high", or wonder what sort of effect they have on him/her
- pills that the decedent has received from a relative or a friend
- pills that the decedent has bought on the "black market" or stolen

SLEEPING PILLS/SEDATIVES

Alprazolam	Glutethimide	Rohypnol
Amobarbital	Halcion	Secobarbital
Apodorm	Heminevrin	Sobril
Apozepam	Iktorivil	Sonata
Aprobarbital	Imovane	Stesolid
Butabarbital	Mephobarbital	Stilnoct

PAINKILLERS

Actiq	Durogesic	OxyNorm
Coccilana-Etyfin	Fentanyl	Panocod
Citodon	Ketodur	Panocod forte
Citodon forte	Ketogan	Paraflex comp
Dexodon	Kodein	Somadril
Depolan	Maxidon	Spasmofen

Butalbital	Meprobamate	Talbutal
Chloral hydrate	Methaqualone	Temesta
Diazepam	Methohexital	Thiamyal
Dormicum	Mogadon	Thiopental
Ethcholorvynol	Nitrazepam	Triazolam
Fenemal	Oxascand	Xanor
Flunitrazepam	Pentobarbital	Zopiklon
Fluscand	Phenobarbital	

Dexofen	Metadon	Subutex
Dilaudid	Morfin	Temgesic
Distalgesic	Nobligan	Tiparol
Dolcontin	Norflex	Tradolan
Doleron	Norgesic	Tramadul
Dolotard	Opidol	Treo comp
Doloxene	OxyContin	

Pills do NOT count as drugs if they have been prescribed by a doctor and the decedent took them in the prescribed dosage.

Appendix G.
Project Interviewer Qualifications

Last name	First name	Degree or experience
Caulkins	Chris	M.S.
DeMello	Elaine	MSW, LCSW
Humphries	Terresa	Ph.D.
Kelly	Anne	Ph.D.
Marquina	Graciela	MSW
McCord	Janet	Ph.D., FT
Piotrowski	Nancy	Ph.D.
Reidenberg	Daniel	PsyD, BCPC, CMT, FAPA, DAPA, CRS, CPAI
Schnell	Janet	LSW, LSW
Sutton	Steven	MSW, LCSW

Commonly Used Abbreviations and Acronyms

SOF	Special Operations Forces
USSOCOM	Special Operations Command
AAS	American Association of Suicidology
WIRB	Western Institutional Review Board