Defense Suicide Prevention Office Podcast Transcript

Postvention

Dr. Alicia Matteson:

Thank you for joining DSPO's Mental Health is Health: Maximizing your Well-being podcast. I am Dr. Alicia Matteson, senior adviser for psychological health at the Defense Suicide Prevention Office. Today, we're going to talk about postvention with Dr. Mary Bartlett, the associate professor of leadership at the Air University Ira C Eaker Leadership Institute at the Air War College at Maxwell Air Force Base. Prior to her current position, Dr. Bartlett served for 10 years as a mental health consultant and trainer for leadership across the Department of Defense. Her principal areas of research are suicide prevention and postvention, resilience, and she is an international speaker and published author in those areas. She's a Nationally certified counselor, licensed professional counselor, a certified family life educator, and is credentialed as an MBTI certified practitioner, emotional intelligence certified trainer, master resilience trainer, and master trainer for the Suicide Prevention Resource Center. So, welcome Dr. Bartlett. I am so excited to talk to you about postvention and what you've learned about the best ways to support the military community following a suicide event. Would you please take a moment to tell our listeners about yourself and your background?

Dr. Mary Bartlett:

Absolutely. First, thank you Dr. Matteson for the invitation. I so appreciate being here and it is always a pleasure to work with your organization, especially to talk about this particular topic. In terms of myself and my background, let's see, I have been a clinical mental health counselor for 27 years. I've been in academia for 22 years. I have worked with thousands of clients who have presented with thoughts about suicide. I do consider myself a clinical survivor of suicide. Obviously working with suicidal clients, I have lost a variety of clients. I rose up to the ranks of a practitioner and then went into academia when I realized that people clinicians were not being well trained in working with suicidal clients. You know, 20-some years ago that was a very small portion of any crisis class in a graduate class for psychologists, psychiatrists, social workers, and counselors. So, that sort of what speared my interest in the topic, and after about 10 years in academia, I decided that was about the time that the military suicide rates were going up in particular the Air Force suicides, and I decided to step away from serving as a clinical director and academic and began my own consulting business. I traveled for about 10 years pretty intensively working with all the different branches, helping them really with the prevention, because 15 years ago when an organization would invite me to come and train people after a suicide they were focused on the prevention. I would say you've just had a suicide, well how about I also come and talk to you about postvention? It was not very well understood and so a lot of military leaders gave pushback. We don't know what that is. We really know we need to focus on prevention and over the 15 years I continued to advocate across the Department of Defense that we really need to get the postvention.

After 10 years of consulting with DOD organizations, the Air Force invited me to come and work at Air University as essentially doing mental health consulting, because they realized that suicide was transcendent across all professional military education, and to get into all the different schools, even though not everyone comes in residence, we could at least have some touch points.

So, about nine years ago I joined Air University to teach leadership courses and help not only Air University infuse postvention training into all of their PME, but to collaboratively work with the Department of the Air Force and the Department of Defense which I have been doing now for nine years.

Dr. Matteson: Oh thank you so much. It's tremendous how many years that you have been working in the suicide prevention space. You mentioned the term postvention several times and I was wondering if you could just take a minute to share with our audience what postvention is?

Dr. Bartlett: Yes, absolutely. So, different organizations have conceptualized it differently than the way I define it when I am teaching. It is everything that people in a community or organizational leaders will do after an attempt and after a completion of suicide or a death by suicide, if you will. So, it's kind of a two-pronged approach. We need to address both an attempt and the rebuilding of the community after that. It's everything that people in a community and leaders in the military organization will do after there's been an attempt of a suicide to help that person and possibly reintegrate them back into their organization.

The second prong, of course, is what will leaders do to rebuild their communities and promote healthy healing after someone dies by suicide?

Dr. Matteson: Now my understanding is that there's evidence that after a suicide death, after a suicide event, there is elevated risk for those who are affected. Could you speak to that elevated risk a bit?

Dr. Bartlett: Yes, so, it's a fascinating journey when you think about it. When as practitioners, when we identify someone as an imminent danger, we refer them to the hospital because we really believe that they may potentially die that night. We're sending them there for medical stabilization. Oftentimes a two or three-night visit won't remediate their suicidality. I think that the branches do a good job after an attempt to get someone into intensive outpatient so that the person can work on actually remediating their suicidality. But what research shows is that that 30 to 90 days following a suicide attempt the person is at an even more elevated risk for their suicide. Now the good news on that is that research also shows that most people that attempt a suicide don't go on to die by suicide, but what's important to help leaders, and especially I think frontline leaders understand is that when this person has made an attempt and is reintegrating back into the organization, because we know that that's a high-risk time, we need to equip leaders to understand what is the best way to support that person whether they're going to be medically boarded or discharged or stay in the Service. Interestingly many of our Service members who attempt actually do not get medically discharged and so it becomes even more important.

Now, the other aspect of this is that research also shows that over the course of 12 months, a person's suicidality will likely go down if they're given the right support and interventions. However, even over the course of 12 months, they stay at an elevated risk even beyond that initial 90 days. So, it does go down, but even after 12 months they can be at an elevated risk for at least their thoughts about suicide because the suicidal thoughts don't happen overnight, they are not going to go away overnight, but we absolutely must equip our communities, our leaders, and our frontline supervisors on what are they going to do and how can they best support a person who's still having potentially high suicidal thoughts when they are returning even after a five or six-week intervention to address it.

Dr. Matteson: Thank you so much. So, really postvention, there is an immediate need to provide postvention after a suicide event, but truly it extends into the future. So, I was wondering if you could

share with the listeners how you have promoted and advocated for postvention both immediate and ongoing?

Dr. Bartlett: Yes. Can I just address what I think there's an important point to make, and then I will absolutely address how in 15 years with the Department of Defense I've promoted the training of postvention, the education of it I think it's important to understand. I look at postvention in two phases. The first phase is when there is a person that dies by suicide, or even the attempt, that immediate response to the crisis or the death. When it's a death, it's helping people move through that potential memorial service and the immediate aftermath and the profound ripple effect that people experience whether they knew the decedent or not. I look at that in that first 90 days after an attempt or a death by suicide as phase one. There are a series of steps and strategy, you know, protocol, evidence-based interventions that if leaders and community people understand because this is a public health issue if they understand they can actually decrease the likelihood for another attempt or completion.

Phase two to me - in my merry brain - is the longer term. How do we help both the person who's attempted suicide during the rest of those nine months when they may still be at an elevated risk? How do we help the leaders? How do we help those that they're working within their military organizations and in the case of a death by suicide, phase two what do we want leaders to do to help rebuild that community, rebuild the sense of being robust, and getting people back to what I call pre-suicide operational status? I think it's important to explain that I'm not encouraging or teaching people to talk about the suicide for the next nine months and in fact, good, effective phase two postvention is not necessarily talking about the suicide but discussing the things that are truly makes true postvention prevention. Talking about connection, belonging, feeling like a person makes helping people feel like they have a purpose, and a sense of value, addressing hopelessness, loneliness, resilience, teaching those skills. When we get the leaders to focus on that in that longer-term phase, it is what becomes the prevention side of effective, efficacious postvention.

So, thank you for letting me address that. Now on to the specific question. Over the last, you know, this is the interesting part, postvention is not new. This is, you know, I speak all the way from you know, on the officer side, SOS, all the way up through teaching at the senior leader orientation course for the Air Force which is our one-star generals and their spouses. I teach even two, three, and four-star levels and on the enlisted side all the way from an NCO Academy through the Chief's Academy. What's interesting is that people, even now after I've been teaching it for more than 15 years, still we have people that haven't even heard of the term. It's funny to me sometimes when I'm teaching, I'll get feedback, you know, written feedback, says Dr. Bartlett just made up this term postvention. She doesn't know what she's talking about. I'd like to clarify in this podcast that all words are made up. Every single word in language is made up, right? But this is not a made-up word. This term was coined by the founder of the American Association of Suicidology, Ed Shneidman. He coined the terms suicidology and postvention. So, it's not a new term and I can speak to the side of the Air Force, the idea of postvention is not new. Back in 1995, when the Air Force initially rolled out its prevention initiative, if you will, postvention was a part of the 11 core elements that they knew they needed to address. The challenge was back in 1995, as I mentioned, when the numbers were increasing the focus was on prevention and intervention. It wasn't that it wasn't understood or that the Department of the Air Force didn't know that it existed, but I don't even think it was coined postvention in those 11 core elements. I think it was termed something different, so the focus wasn't on it.

Then in 2006, I believe, the first checklist on postvention for leaders was developed and that gave them a sense of control and direction. What is this aftermath and what are their responsibilities that they need to do after an attempt or completion?

That was the primary document that helped leaders move through the postvention. That document wasn't even readdressed or reformatted until 2011 and then what happened and what thrust postvention into the awareness of, I think, not just the Air Force but the Department of Defense, but specifically for the Air Force, in 2019 it experienced its highest number of suicides in its entire history. I think at that point it was you know our 73-year history. That for the first time gained the awareness of the most senior-level people. Prior to 2019, for those 10 years when I was a consultant, I have been, you know, pounding the pavement in the Pentagon speaking to anyone that would listen to help them understand we cannot just focus on prevention and intervention, but we must also focus on postvention. I want to I want to clarify I attribute my efforts that began 15 years ago to Ken Norton who was the executive director at that time of the organization Connect in New Hampshire and Connect was one of the first I think National organizations that really focused on postvention. He was not making headway and he needed to step back and he literally in a meeting said 'Mary, I need you to champion postvention." I know you get this, and we cannot turn our eye to helping the Department of Defense understand that this is crucial. It was like he gave me the guidon, if you will, and I took that very seriously because I understood it. It was at that juncture that I began pounding the pavement anywhere I could, in every organization to educate, and I had to do that very gently very politically correctly, you know, with any organization I continued to include it in my conversation and advocate and explain what it meant and eventually part of the Air Force and leadership began to understand it and say will you come now; after 2019 was really the peak when organizations started saying will you come and speak on postvention, not just the prevention and the intervention, and thus opened the gates in 2019. I regret that it took a high number of suicides to open that pathway, but I am grateful for the journey that we've had and that we are now there.

Another interesting facet in the 15 years of advocacy is that 15 years ago I was talking to the suicide prevention program managers for the Air Force. Some of them understood it. Some of them understood the term, but there was still pushback by some our airmen don't really need to understand that side of it. I, you know, obviously beg to differ and in that advocacy with program manager after program manager and leader chief of staff after chief of staff, finally it was General Golding in 2019 that gave the blessing and said yes go ahead and put at least the term and a definition in the annual training. That was a huge accomplishment. Once that happened, and at the same time coincided with Air University bringing on a suicidologist in the mental health area and saying you're going to teach leadership, but you're also going to help move this into our PME, I was able to get the education of postvention into many of those PME classes. It wasn't formally sanctioned. It was sanctioned and embraced by Air University. We recognized that it was our first in-road, that again, we were missing many people and that's why I don't just teach it at a university. I was allowed to continue teaching it across the Air Force and DOD. The stars align and then we start to see standard operating procedures being written to me which hit the heart. The checklists were fine, but the heart of postvention is how do we rebuild communities? How do we reach their hearts? How do we support the survivors? How do we get people back to a state where they're operationally focused instead of focusing on the enormous psychological pain that they're experiencing whether they knew the person who died or not? Because this is what makes postvention so important and nebulous. You don't have to have known the person who died to be impacted by it. It conjures up unresolved grief for people and why, unlike losing people

to cancer and other horrible things, you know, tragic accidents, the process for recovery in the postvention phase has some nuances that the survivor is going to go through, that if our leaders understand they can more efficaciously address to hopefully again prevent contagion and promote the building of resilience. So, that's a very brief synopsis of how have we step by step, and again this has been a collaborative effort, many people you know the expansion into A1Z in the Air Force side, the development of resilience initiatives for all branches, the recognition that and the wonderful work by Dr. Craig Bryan, that we need to focus on quality of life issues and some of the more basic things that tend to feed into the psychological distress, that make a person go down that trajectory to think about dying.

So, it's been a tremendous collaborative effect of finding the right people who didn't give up on this concept and understand that postvention is prevention.

Dr. Matteson: Dr. Bartlett, we just have just depths and depths of gratitude to you and to others who have advocated for years the importance of really a full spectrum suicide prevention public health approach that does include prevention, intervention, and postvention. Because of professionals like yourselves, we are now really standing in a space where we do have an incredible opportunity at this time to infuse a very comprehensive suicide prevention approach to include a robust system of postvention across the Department of Defense. Thanks to our Secretary of Defense, who has been a tremendous advocate for finding out what best practices are, finding out what is the evidence for suicide prevention that will help us save lives, and he has done some very tangible steps to help the Department of Defense at this time really get after standing up this complete system.

We also have the recent publication of the National Strategy for Suicide Prevention. I did a word search and postvention is mentioned 30 times in the National Strategy. So, again thanks to the tireless advocacy of yourself and others we are in a position now to truly realize a robust system, a full system of support and care that includes making life worth living. You mentioned the quality of life as well as how are we intervening and then how are we mitigating risk after suicide death or a suicide event. So, given where we are now, knowing that we are in a position to truly provide for our DOD community, which by the way 70% of our members and our family members live off of installations and in civilian communities around installations. So, I have a two-part question for you given where we are now, what do you see as the three most important steps that we can take in the DOD and then across the Nation, and across our civilian community, same question, what do you see as the three most important things that we could do at this time?

Dr. Barnett: I believe that there has always been the process of linking arms with all the many National organizations. Again, collectively and collaboratively there's room at this table for everyone as long as we're practicing from best practice and evidence-based interventions. That's really important linking arms with the many organizations and continuing education. So, that's the first thing, linking arms; recognizing we don't have to do this alone. This is not just on the Department of Defense, you know, and the branches. So, linking arms and in that process holding people accountable to make sure that they're using the best practice and good research, because my experience is that at the tactical and operational level, interventions on postvention often times stem from people not knowing what to do. I always explain throwing something at the wall hoping it sticks because they tried it before and it made them and others feel good, so, we need to make sure that that's where the education component comes in and that's so that's the second. First is linking arms, collaborating with resources, and making sure they are research-driven and evidence-based. The second part is what is all that good information

if we do not educate just across our branches and Department of Defense but within the larger community, because this is a public health issue finding, you know, so the education and we recognize at least in the DAFF, that this is making sure that this gets out through all the levels. This cannot just be a - this is not just a policy issue. This is not just a training issue. This to me is an education issue. Training is more proforma education. That is why the former chief of staff, and now our chairman of the joint chiefs really did support this process. The really wise question was how we get this information, now that we've got it, in, you know, the PME, how do we push it down into the squadron level which is sort of the heartbeat of at least the Air Force? So, the third part of the third recommendation is how do we get it to push it out? So, first, you've got let's join resources and make sure it's research-driven and evidence-based. Let's get people educated. Then the method in which we do it to make sure that it isn't siloed, you know, that we have silos of information. That's the tricky part, I think, the third component of pushing it out to our communities. How do we get this has been an age-old issue, how do we get our Service members, who, like you pointed out, 70% live off the installation, to bring the information? How do we get them acclimated when they have a colleague who's lost a child of suicide to understand how to engage with them in the community? How do we get the information into the frontline levels, so that those who are eyeball to eyeball, being held accountable, look for the risk and protective factors to keep, you know, to intervene? How do we also get that information to that tactical level so that both on the installation, at work, and then off the installation the information is being shared with our families?

One of the ways the Air Force is doing that to get to the families off the installation is by including spouses in the trainings. So, on our resilience website we have a specific family or spouse training on prevention and components of postvention. The chief of staff is including spouses in the training for group and wing and senior enlisted leader command, pre-command training. So, the spouses are being invited. Again, it's that third part that's really hard. We must become more creative, because we can't just be in the classroom setting but that is probably how we're going to begin. So, we've got to have the policy. We've got to have the collaboration. We've got to encourage education.

I have cautioned senior leaders if we programize postvention as we have in many; it's largely prevention. Rather than infusing it into professional development discussions, robust discussions that get people to talk about their experience and you are working actively, you know, let's not forget your incredible advocacy from the Department of the Air Force to the DOD level, because without you and the star, the sun, and the moon shining, or, you know, aligning, we wouldn't be where we are. So, that's an important point, but in addition, finding creative ways to get the information out to the family, so using our conferences and breaking through continued stigma and barriers that people have, and the discomfort people have in talking about grief and psychological pain in the aftermath of suicide. Because let's face it, in our country, I don't think that our Nation does grief or anger very well. This is a different kind of grief. Now, we're asking people to not only go through normal grief stages, but we're trying to educate them on all the other myriads of experiences of grief that are a part of the postvention process. So, I think those are the three things. That might be a bias on my part Dr. Matteson because I am an educator as well as a clinician, but in my many years I see it is the policy that we're driving that's happening that you pointed out. It is education and recognizing. We must work collaboratively, this is for all of us, and it cannot happen just again at the policy level and the operational level, it has to also get out, as you point out, at the tactical, both on and off the installation. That is an issue. It has always been an issue. How do we get our Service members to take this good resilience training that they're getting or prevention training and move it off into their family discussions?

Dr. Matteson: Dr. Bartlett, we are so incredibly grateful for all of the information that you shared with us today. You've certainly given us many, many actions and many approaches to think about as to how do we actually reach our entire community and provide care, support through prevention, intervention and postvention to mitigate risk, to help us truly make life worth living, and so thank you for spending this time with us. Thank you for all that you do tirelessly over several decades for the members of the DOD. For our listeners, thank you so much for being with us today. Please help us spread the word by liking our podcast. Share it with your contacts on social media. To access more podcasts and the resources in DSPO's library, please visit us online at www.DSPO.mil. If you are in crisis or you know someone who is in crisis, please access the National Crisis Hotline by dialing 988. If you are a Service member in crisis dial the same number 988 and press one for the Veteran and Military Crisis Line. Any of us can also access the crisis line by texting 838255. Thank you.