Communication Matters: A Study of Methods of Delivery and the Role of Persuasion in Army Suicide Prevention Training Materials

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by

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Abstract

COMMUNICATION MATTERS: A STUDY OF METHODS OF DELIVERY AND THE ROLE OF PERSUASION IN ARMY SUICIDE PREVENTION TRAINING MATERIALS

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According to the Department of Veterans Affairs' 2018 Suicide Data Report, an average of 20 veterans commit suicide every day. The Army ACE Suicide Intervention Training is based on a battle buddy system and methods of observation for other soldiers in attempt to prevent suicide. The increasing number of suicides among soldiers indicates that the training is not persuasive enough for soldiers to overcome the stigma and seek help. This paper presents research into different methods of formulating suicide intervention training using a rhetorical approach to find improved ways to persuade soldiers who are dealing with intense stress or mental illness to speak up and ask for help.

Chapter 1: Introduction

Suicide has been the second leading cause of death in the U.S. military, exceeding the number of combat-related losses in both Iraq and Afghanistan (Lineberry 871). In 2016, the most recent data indicates the suicide rate for veterans was 1.5 times greater than those who never served in the military. About 20 veterans a day across the country take their own lives, and veterans accounted for 14 percent of all adult suicide deaths in United States (Dept. of Veterans Affairs 2018 Report).

In his statement on September 3, 2013, in commemoration of suicide prevention month, Secretary of Defense Chuck Hagel said, "The Department of Defense has invested more than 100 million dollars into research on the diagnosis and treatment of depression, bipolar disorder, and substance abuse, as well as interventions for relationship, financial and legal issues – all of which can be associated with suicide" (Dept. of Defense), yet the number of suicides in the military remains high. According to Carl Castro, a retired Army psychologist, "it is very clear that nothing that the Army has done has resulted in the suicide rates coming down" (Zoroya). There is no explanation as to why the Army suicide rate increased in the mid-2000s and continues to remain high.

Research and statistics indicate that the issue of suicide is quite complex, because the rate of suicide varies based on many factors. For example, married veterans are at a higher risk of suicide than single soldiers. In particular, older married female soldiers are

at a higher risk, because of the added pressures that come with maintaining a relationship, managing a family, and meeting household needs (Poitras 2). Some other factors that complicate the issue of suicide are:

- Military Occupation: Research shows that suicide rates in combat arms occupations are higher than other occupations (Kessler 7), mainly because soldiers in combat arms are deployed frequently and they are more exposed to trauma and stress.
- Location: A study based on 2005-2012 National Violent Death Reporting System data from 16 states (963 counties) suggests that military and veteran suicides are concentrated in a small number of counties based on population and number or size of the installations and bases in the area (Logan 198, 203).
- Age: According to the VA's 2018 report, the suicide rate of veterans aged 18 to 34 steadily increased from 2006 to 2016, with a jump of more than 10 percent from 2015 to 2016. That translates into 45 deaths per 100,000 veterans, the highest of any age group (Dept. of Veterans Affairs 4).
- Gender: Males are four times more likely than females to complete suicide. Men are presumed to have a higher rate of death due to the lethality of means used (Martin 102). The most common means for suicide among veterans is firearms, with approximately 41% of female and 68% of male veterans suicide deaths resulting from a firearm injury in 2014 (Dept. of Veterans Affairs 47).

- Race: Like age and gender, there are variations in risk factors among ethnic groups or races. Between 1950 and 2005, White, American Indian, and Alaska Native males and females had the highest rates of suicide (Martin 103).

As complex and complicated as the issue of suicide in the Army is, ACE Suicide Intervention Training is the only training available to all soldiers, regardless of component (Reserve or Active Duty), occupation, age, gender, race, or location. The ACE training was developed in 2009 by the United States Army Public Health Command (PHC), and it stands for "Act, Care, and Escort". Designed for soldiers, leaders, DA civilians, and families, ACE is a standardized lesson plan presenting instruction on suicide intervention training to soldiers, and it focuses on the actions required by a "battle buddy" to help prevent suicide (Army G-1, Army Suicide Prevention Program).

The ACE training teaches soldiers to be a battle buddy and pay attention to each other. It talks about symptoms of depression and behavior of a suicidal person. It encourage soldiers to inquire about suicidal ideation, and if a soldier is identified as displaying these symptoms, a battle buddy is encouraged to reach out and care for the individual by escorting the soldier to a source of additional help.

The mandatory suicide prevention program is instituted Army-wide, and it includes suicide prevention video vignettes and PowerPoint presentation slides. Army Regulation 600-63, Army Health Promotion, establishes ACE as a four-hour module to be conducted annually; in reality, ACE training is often condensed to only about an hour in length. Topics in this training include suicide awareness, warning signs of suicidal

thinking and behavior, and intervention skills development. The class is taught by a therapist, the unit chaplain, or just about anyone who has been certified as a suicide prevention instructor. Overall, suicide intervention training focuses on equipping soldiers with skills necessary to help a suicidal buddy (Army G-1, Army Suicide Prevention Program).

Figure 1: Army ACE Suicide Intervention card (Tolzmann)

The establishment of ACE training in 2009 falls short of providing an adequate solution to deal with the high level of stress placed on soldiers due to the multitude of locations, environments, and responsibilities that they face in the dangerous and ever-

changing dynamics of modern warfare. Military members do not face just one enemy in one location for a period of time; there is conflict in every corner: Yemen, Uganda, Syria, Jordan, Turkey, and Chad, just to name a few. Soldiers are going from one deployment to another, this makes a complex suicide issue even more complicated. The *Summary of the 2018 U.S. National Defense Strategy* reveals, "Inter-state strategic competition, not terrorism, is now the primary concern in U.S. national security," indicating yet another change and another dimension of responsibility and stress for the troops (United States, Dept. of Defense 1). As the situation across the globe becomes more complex and suicide rates remain high, a query about the communications and rhetorical strategies can be advantageous in reaching out to soldiers with mental health issues. It's time to refocus attention on the problem of suicide in the Army and re-evaluate Army suicide intervention training.

Army suicide prevention training needs to use rhetorical language and methods to make soldiers realize that as long as their heart is still beating, they have a purpose and a reason to never give up. Conquering one's weaknesses and swinging with life's ups and downs is what each and every one of us is destined to do. This paper presents research into different methods of formulating suicide intervention training using a rhetorical approach to find improved ways to persuade soldiers who are dealing with intense stress or mental illness to speak up and seek help.

First I will introduce the ACE training, its objective and what it has to offer. Then using textual analysis, I will examine the ways that the ACE training's effectiveness could be improved by using persuasive methods and tactics, using the principles of

rhetoric. Certain elements of the training such as the "buddy system" to intervene are not fully developed to provide soldiers with tools to be able to convince them to seek help. The training does not address the stigma of mental illness and the perception of appearing to be weak or unstable. Lastly, it fails to provide all the venues available to soldiers to manage stress and get help for mental illness.

Second I will provide some research conducted on the importance of rhetoric in teaching and interacting with audiences. These studies are based on Jordynn Jack's notion of neurorhetoric, paired with Thornton's notion of the rhetorical brain and Burke's concept of identification. I will analyze and suggest alternative tools that an audience (in our case soldiers) may benefit from by considering the "neural correlates" of rhetorical concepts such as pathos, presence, identification, or persuasion to the audience, their impulse and responses, while maintaining the significance of "critical and rhetorical perspectives on discourses involving the brain (Jack 406). Recognizing the "emotion button," and its use can be helpful in creating an effective training session. What alternatives might there be to these constructions? How might the theories and methods of rhetoric guide revisions that recommend these alternatives?

Lastly, based on analysis of the training and research on the role of rhetoric on impacting the human brain and behavior, I will provide a model that can help to develop more effective and persuasive suicide prevention training that can motivate soldiers who need help to step forward and seek help. The findings from these questions will allow for the development of training that might be more appealing and persuasive to soldiers who are having difficulty dealing with life stressors that could result in suicidal tendency.

Chapter 2: Training Analysis

2.1 ACE Training

According to the Suicide Prevention Research Center, The *Army ACE Suicide Intervention* (ACE-SI) Program is set to be up to four-hours to provide soldiers with the awareness, knowledge, and skills necessary to intervene with those at risk for suicide" (Army ACE Suicide Intervention Program).

The purpose of ACE is to help soldiers and junior leaders become more aware of steps they can take to prevent suicide and be confident in their ability to do so. ACE urges soldiers to directly and honestly question any battle buddy who exhibits suicidal behavior. The battle buddy should ask a fellow soldier whether he or she is suicidal, care for the soldier, and escort the soldier to a source of professional help. This training is supposed to help soldiers avoid letting their fears of suicide govern their actions to prevent suicides.

The Army ACE Suicide Intervention Program lists the objectives of ACE training as follow:

- Feel increased individual and group responsibility for the well-being of others.
- Have increased awareness of stigma and its negative effects on help-seeking.

- Have increased knowledge and skills for identifying, intervening, and referring suicidal Warriors for help.
- Have increased competence and confidence in the application of these skills.
- Have increased knowledge of military and community resources for Warrior referrals (Army ACE Suicide Intervention Program).

In this chapter, I will review and analyze parts of ACE training and its objectives that are mentioned above in order to identify gaps in the training.

2.2 Increased Responsibility for the Well-Being of Others

"Wishing to be friends is quick work, but friendship is a slow ripening fruit." – Aristotle

The first concern with ACE training is that it focuses on a *battle buddy*, and *prevention* is dependent upon someone else's *intervention*. The training not only doesn't provide tools to empower the soldier to be in charge of their mental health, it gives the impression that the responsibility falls on a friend or leadership to recognize signs of suicidal tendencies and take steps to prevent. The training is telling soldiers to pay close attention to each other and each other's behavior in search of indications for mental health issues and potential suicidal thoughts. It encourages soldiers to: Ask their *buddy* ("are you ok?"), Care for their *buddy* ("everything is going to be ok, I will help you"), Escort their *buddy* ("let's go talk to the chaplain/commander"). The Army's concept of "battle buddy" is a partner/friend assigned to a soldier. Each battle buddy is expected to assist his or her partner both in and out of combat. In theory (and in some cases, in

reality), the battle buddy concept may help save lives and keep soldiers out of trouble. This notion is one of the factors that led the U. S. Army Training and Doctrine Command (TRADOC) to mandate that all recruits in Basic and Advanced Initial Training (AIT) be paired in teams of battle buddies. TRADOC feels that this practice has the following benefits:

- provides soldiers with sources of mutual support and assistance,
- assists in the development of teamwork,
- develops a sense of responsibility and accountability among soldiers,
- improves safety during training, and
- reduces the likelihood and opportunity for misconduct, sexual harassment, and suicide attempts/gestures (Ramsberger 1).

However, upon completion of Basic Training and AIT, soldiers do not report to their unit of assignment with their battle buddy and a battle buddy is not allocated like a weapon or gear, the Army doesn't order friendships. Like anywhere else in the world soldiers in the Army need to make friends on their own. Ironically, according to Lieutenant General Charles D. Luckey, Chief of Army Reserve and Commanding General U.S. Army Reserve Command, soldiers commit suicide for two reasons: 1) if they feel they don't belong to a team; there is not a team that they belong to or the team doesn't care about them, and 2) burdensomeness, soldier feels being a burden to the team (U.S. Army Reserve YouTube Video). Unfortunately, both of these reasons are very common in the Army due to the high standards and expectations of being a soldier, especially as you obtain rank and become more senior in grade. These standards and

expectations create barriers in making friends in the Army, mostly due to the fear of being a burden or a failure.

The National Institute of Mental Health (NIMH) lists the main risk factors for suicide as:

- A prior suicide attempt
- Depression and other mental health disorders
- Substance abuse disorder
- Family history of a mental health or substance abuse disorder
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Being in prison or jail
- Being exposed to others' suicidal behavior, such as a family member, peer, or media figure

Other risk factors specific to soldiers that are similar to the general population but exaggerated in the Army due to the culture and line of work are:

- Relationship problems (loss of girlfriend or boyfriend, or divorce)
- Work-related problems
- Transitions (retirement, permanent change of station or discharge)
- Significant loss
- Current/pending disciplinary or legal action
- Setback (academic, career or personal)

- Severe, prolonged and/or perceived unmanageable stress
- A sense of powerlessness, helplessness and/or hopelessness
- Financial problems (Tolzmann 4)

In order for a person to recognize these symptoms in another it requires building a close friendship over some period of time. In a new report published in the Journal of Social and Personal Relationships, Jeffrey Hall found that:

> Casual friendships emerge around 30 hr., followed by friendships around 50 hr. Good friendships begin to emerge after 140 hr. Best friendships do not emerge until after 300 hr. of time spent. Whether spending 30 or 600 hr. of time together, the percentage of all relationships formed in closed systems (e.g., work, school) remains relatively constant. Logistic regressions offered 3-point estimates: 94 hr. when acquaintances become casual friends, 164 hr. when casual friends become friends, and 219 hr. when friends become good/best friends (Hall 10).

This research result means that in order to build a close friendship, one requires the time and opportunities to spend in activities such as hanging out, joking around, playing video games, and bonding over activities. The hours spent working together just don't count as much as time spent together socially. One has to put that time in; it is not possible to snap your fingers and make a friend. Maintaining close relationships is the most important work people do in their lives — most people on their deathbeds agree (Hellman).

The Army's social dynamic is heavily influenced by frequent reassignments and relocations (usually within three years for Active duty members). These relocations don't

include taking your battle buddy with you. By the time a soldier is settled in the new location and starts making friends, it's time to move again. It is even more difficult in the Army Reserve, where soldiers gather from near or far parts of the country once a month for two days, which is mainly spent in training or busy accomplishing the weekend's tasks. The term "buddy" as defined as "a close friend" or "become friendly and spend time with," doesn't exist for many soldiers.

Additionally, even if a buddy system is established successfully, it is very difficult to identify the signs of suicidal thoughts in a person, "[e]ven among people who have risk factors for suicide, most do not attempt suicide. It remains difficult to predict who will act on suicidal thoughts" (NIH, Frequently Asked Questions).

While the buddy system can be useful in many ways, it is not practical for the systematic conditions of military life, it is structurally difficult to actually make close friends to becomes buddies. As a result a more realistic approach to the discourse might be acknowledging the realities of the system and re-framing the training accordingly.

2.3 Increased Awareness of Stigma and its Negative Effects

The second concern with ACE training is that it fails to fully address the issue of stigma. In the Army, soldiers believe that admitting to having mental health issues will impact their careers. They worry that they will be viewed by their peers and superiors as weak and unstable. They fear that it may jeopardize their security clearances and even result in their separation from the service (Sharp et al. 145).

The Army may generate certain stigmatizing beliefs that create difficulties in asking for help. For example, the importance of achieving the Army objectives, the

cultures of reliance upon each other, masculinity, self-sufficiency, and the shame of being sick or avoiding work are just a few reasons for a soldier not reaching out for support. Another obstacle is that the operational readiness requirements, which includes maintaining good health (physical and mental), create conflict in choosing between disclosure of health problems in order to access care and the potential negative effect upon the operational effectiveness and consequently one's career. Overall, Army objectives, structures, and cultures may all contribute in creating barriers for soldiers who need help dealing with mental and emotional strains (145). The Table below ranks these barriers based on research conducted in February 2014 by Sharp et al. using a quantitative methodology.

Stigma Item	Prevalence, %	95% Confidence Interval
My unit leadership might treat me differently.	44.2	37.1, 51.4
I would be seen as weak.	42.9	36.8, 49.0
Members of my unit might have less confidence in me.	41.3	32.6, 50.0
It would be too embarrassing.	36.1	29.0, 43.2
It would harm my career.	33.4	27.9, 38.9
My leaders would blame me for the problem.	25.5	18.6, 32.5

Abbreviation: PSBCPP-SS, Perceived Stigma and Barriers to Care for Psychological Problems-Stigma Subscale.

Table 1: Item Weighted Prevalence from Studies Published in 2004-2014 Using the PSBCPP-SS (Sharp et al. 158)

Stigma is recognized as one of the variables that influences a soldier's decision to seek psychological treatment. Greene-Shortridge and Britt studied more than 3000 soldiers by conducting a survey evaluating whether they were suffering from psychological problems and asked them to identify any stigma related to seeking help for their psychological problems. They also considered the condition of the leadership and the unit's climate (Greene-Shortridge et al. 158). Greene-Shortridge and Britt learned that the stigma and the barrier in asking for help are mainly because of the reported quality of leadership (158), which is consistent with Sharp et al. findings summarized in Table 1 above.

If soldiers experience and suppress the stigmatizing behaviors of those around them, they will likely form self-stigma. The self-stigma can lead to lower self-esteem, which in turn, could cause lack of motivation and desire to seek care. Those individuals could view themselves as responsible for their disorder by believing that they should have control over their condition and/or feel responsible for experiencing symptoms of PTSD (Post-Traumatic Stress Disorder) (159). The Figure 2 below displays interruption of the path from PTSD to receiving mental health due to stigma.

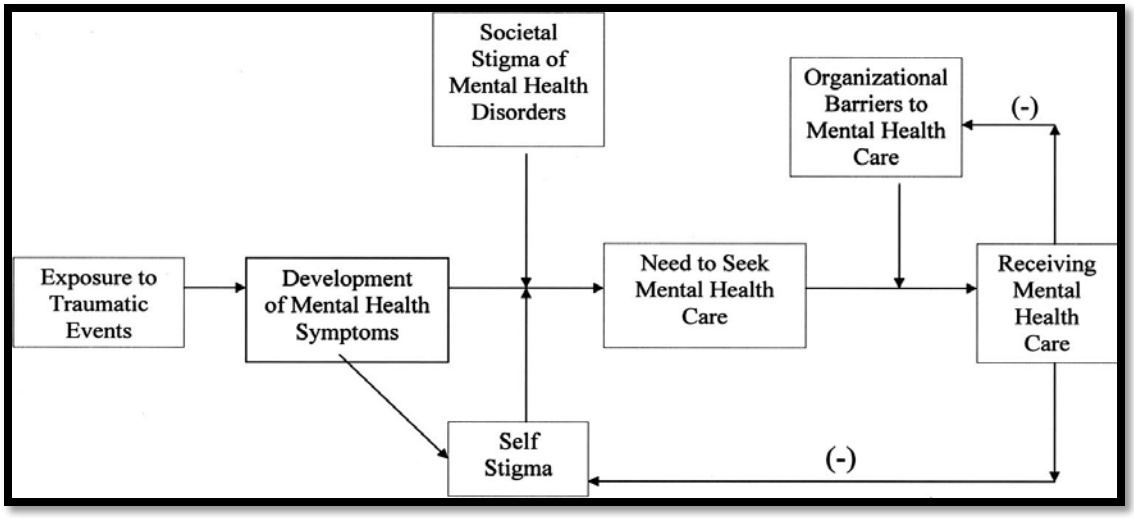

Figure 2: A path diagram reflecting how stigma and barriers to care can affect getting treatment for psychological problems (Greene-Shortridge 159)

Based on this study, Greene-Shortridge and Britt suggest that interventions for reducing the stigma of mental health problems should address both societal and self-stigma. They recommend Corrigan and Penn's proposed methods for reducing the stigma. These strategies are: 1) protesting, which consists of informing society that they should not possess negative stereotypes about mental illness; 2) educating and providing factual information to society's members about mental disorders, and 3) promoting contact with individuals who have a mental illness, which involves reducing negative beliefs about mental illness by placing the public in direct contact with the stigmatized group (159-160).

The ACE suicide intervention training not only doesn't recognize the two forms of stigmatization (societal and self-stigma), it doesn't offer any of the suggested strategies. Here is the only slide on the issue of stigma that is presented during the ACE training:

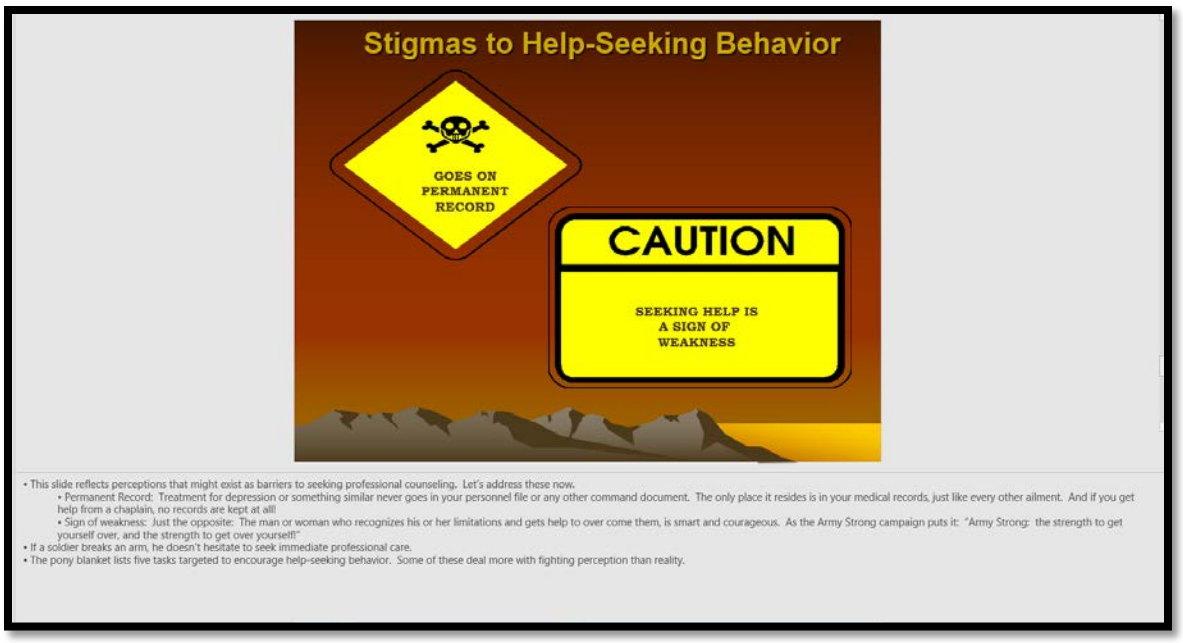

Figure 3: Army ACE Training, Stigma Slide (Army G-1, Army Suicide Prevention Program)[1]

The notes accompanied by the slides read:

- This slide reflects perceptions that might exist as barriers to seeking professional counseling. Let's address these now.
- Permanent Record: Treatment for depression or something similar never goes in your personnel file or any other command document. The only place it resides is in your medical records, just like every other ailment. And if you get help from a chaplain, no records are kept at all!

[1] While there are variations of training slides and most units create or modify their own training slides, the training slides used as reference for this thesis are from Army G-1(Army Suicide Prevention Program) Web-Site. http://www.armyg1.army.mil/dcs/docs/Suicide%20Awareness%20and%20Prevention%20briefing%20w-Speaker%20Notes.ppt (last accessed November 26, 2018).

- Sign of weakness: Just the opposite: The man or woman who recognizes his or her limitations and gets help to overcome them, is smart and courageous. As the Army Strong campaign puts it: "Army Strong: the strength to get yourself over, and the strength to get over yourself!"
- If a soldier breaks an arm, he doesn't hesitate to seek immediate professional care (Army G-1, Army Suicide Prevention Program).

The message the slide notes convey is that the stigma doesn't exist, that's it. It doesn't protest, educate, or encourage contact with mentally ill soldier as it is suggested by Greene-Shortridge and Britt.

The stigma is an added stress to a soldier who is already suffering from mental distress. The fear of social exclusion and threat to their career due to mental illness may prevent them from seeking help. Additionally, soldiers' perceptions of society holding them accountable for their psychological problems may stop them from pursuing treatment.

2.4 Increased Knowledge of Military and Community Resources

Lastly, the issue with ACE training is its overall impact on soldiers. The standard ACE training slides work against the actual needs of suicidal individuals. According to the ACE training, once a soldier is identified as someone who is struggling with depression or suicidal thoughts, he/she should not be left alone. The training advises soldiers to escort the individual to "the chain of command, a Chaplain, a behavioral health professional, or a primary care provider" (Army G-1, Army Suicide Prevention Program). Oftentimes, the training may provide the number to the Military Crisis Line.

However, the training fails to send a message that seeking mental health treatment can be performed at any point and not just during moments of crisis. It also doesn't include other resources available to soldiers, such as:

- Military OneSource: provides up to 12 free confidential sessions to soldiers and their immediate family members with professional specialized behavioral therapist in their area along with a 24/7 online and call center to support and aid.
- Veterans Affairs (VA) mental Health: The VA offers a variety of services that are not made known to soldiers and not fully explained. According to the *Guide to VA Mental Health Services for Veterans & Families* some of these services are:
    - Around-the-clock service; emergency mental health care is available 24 hours per day, 7 days a week at VA medical centers. In the absence of a 24-hour emergency room at VA medical centers, the services are provided through a local, non-VA hospital. Telephone evaluations at VA medical centers and the national crisis hotlines are also available 24/7.
    - Short-term, inpatient care.
    - Outpatient care in a psychological rehabilitation and recovery center (PRRC) for veterans with serious mental illness and significant problems in functioning.

- Regular outpatient care, which may include telemedicine Residential Rehabilitation Treatment Program (RRTP) for Veterans with a wide range of mental health problems (such as posttraumatic stress disorder and substance use disorders and/or rehabilitative care needs (such as homelessness, job training, and education) who would benefit from treatment in a structured environment for a period of time.

- Warrior Canine Connection: A program that utilizes a Mission Based Trauma Recovery model to help recovering Warriors reconnect with life, their families, their communities, and each other (Warrior Canine Connection).
- Yoga-Based Classes for Veterans with severe Mental Illness (BSR): The BSR classes were developed within interdisciplinary focus groups that included professional yoga teachers, the director of the PRRC, psychiatrists, psychologists, nurses, occupational therapists, and physical therapists (Bake 20).

The stigma of mental illness prevents soldiers from consulting with their chain of command or their commanders. Soldiers are also reluctant about speaking to a Chaplain because of the connection with particular religious or spiritual beliefs. The term "behavioral health professional" is very broad and unclear. For the majority of Army Reserve soldiers who are not enrolled in or familiar with the VA program, it may mean, seeking professional mental health through civilian insurance. Nevertheless, the

combination of stigma and not having enough information on how or where to seek help, creates various obstacles for soldiers who are suffering from depression.

Therefore, this research will explore other methods and tools using rhetoric and professional communication to provide important insights and changes to these existing processes, alongside the intervention training that ACE provides. The research is focused on proactive training for the entire force aimed directly at those who might be struggling with thoughts of suicide. An effective training curriculum should offer tools and methods to help soldiers to understand their mind and emotions better, and to facilitate with ways to overcome difficult obstacles without considering suicide as a solution.

Chapter 3: Literature Review

ACE training doesn't view mental illness, depression, and suicidal thoughts as concepts of the brain and emotion, but rather as physical objects that can be manipulated. Rhetorical perspective or neurorhetoric, on the other hand, offers a different outlook on persuasiveness and how people can identify and reach out to people in a mental health crisis.

The ACE model relies on a method of persuasion and action that isn't rhetorically sound for a number of reasons: 1) it requires soldiers to intensely read each other for signs of depression that aren't always clear or within the expectations of the Army culture; 2) it doesn't provide soldiers with good persuasive tools to convince their "buddies" to seek treatment, even if they are able to assess and see how they are in distress; 3) it offers a set of solutions that are opposed to many other cultural and social factors of the experience of being a soldier, such as admitting to needing help (which is perceived as weakness). Viewing the ACE model through the theoretical concept of neurorhetoric, in particular, demonstrates the rhetorical ineffectiveness of the model.

This chapter will first explore and define rhetoric, the art of persuasion, and then it will introduce some concepts that are based on rhetoric. These concepts are: Jordynn Jack's neurorhetoric, the study of neuroscience and rhetoric to better understand ways that words connect in the brain and stimulate thoughts and beliefs; Davi Thornton's

rhetorical brain, explaining the influence of society on the brain and its rhetorical ways that shape our brain; and Kenneth Burke's identification concept, which states that in order to persuade effectively, one must relate. These concepts all provide tools that can help us to find different methods and approaches to reaching out to soldiers and persuade them to consider options other than suicide.

3.1 Rhetoric: The Art of Persuasion

The Greek philosopher Aristotle called rhetoric the art of seeing the available means to persuasion, or strategic use of communication to accomplish purposes with target audiences. Rhetoric inspires the way we think, which can become physically embedded in our mind, forming our belief structure and connecting to emotions.

In her article, *Science, Rhetoric and the Creation of Preferred Realities*, Dr. Marilyn Wedge explains that "Rhetoricians are not constrained by facts or truth. Their goal is to get their audience to believe in a 'preferred reality' that is the reality they want people to believe. Because the goal of the rhetorician is to sway opinion" (Wedge 1). Dr. Marilyn Wedge is a family therapist and she uses "preferred reality" in order to encourage parents to utilize family therapy as an effective alternative to psychiatric drugs for kids. In her book, instead of focusing on her failures, Dr. Wedge tells the readers of her cases where her method of therapy was successful. Dr. Wedge's book is rhetorically aimed to a specific audience, parents with ADHD children, and she credits her success to Aristotle's "the art of rhetoric – the selection and arrangement of data to strengthen an argument" (Wedge).

So, rhetoric as defined by the ancient Greeks is the art of persuasion. It relates to language, words, presentation, and even visualization. Just as Dr. Wedge used rhetoric to convince her audience - of probably very emotionally invested parents with potentially strong biases towards a more conventional treatment – to consider family therapy over drugs, rhetoric should also be an important part of the Army suicide training.

3.2 Neurorhetoric: The Study of How Rhetoric Shapes the Human Brain

Jordynn Jack, a rhetoric scholar, and Gregory Appelbaum, a neuroscientist, together created the concept of neurorhetoric. In a lecture to students at North Dakota University, Dr. Jack explains neurorhetoric means people in the field of rhetoric should study the rhetoric of neuroscience, how neuroscience persuades and how scientists make arguments in neuroscience. It's about learning and understanding how the brain works and communicates. It's looking at the ever increasing persuasive appeal of neuroscience and neuroimages. Neurorhetoric looks at neuroscience research and focuses on ways rhetoric and rhetorical theories can add to the dialog. Rhetoricians in neurorhetoric can help neuroscientists with the use of language and structures in order to create a strong and convincing argument (Jack).[2]

Based on brain imaging, neuroscientists claim that the brain is the source of all human thought, emotion, and behavior. In 2013, President Barack Obama devoted a research program to a brain mapping project called the Brain Initiative that would hopefully lead into intervention of treating brain diseases and mental illnesses such as

[2] On September 9, 2014, Dr. Jordan Jack gave a talk about "Creative Brains: Rhetorical Approaches to Neuroscience," to students at North Dakota State University, available at https://neurorhetoric.com/2014/09/09/creative-brains-rhetorical-approaches-to-neuroscience/.

Parkinson's, epilepsy, schizophrenia, and PTSD (National Archives and Records Administration). The neuroscience advancement has become of interest to all, the media and public. More magazines issue articles on neuroscience, the brain, and ways to improve and train the brain. People who are aging are encouraged to improve their brains through different kinds of brain training programs. For example, Lumosity, a brain training regime, brain diet, and brain exercise that are all focused on benefits like improving memory and creativity. The brain falls under something that is referred to as technologies of the self, so it's not just our body that we need to perfect, but it also our brain (Jack). The key relationship between neuroscience and rhetoric is the use of language and how words are used and defined.

Jack and Appelbaum use studies of autism to explain the neuroscience of rhetoric, bringing awareness to the use of language, persuasion, and communication through scientific research. People with autism are challenged with social skills, repetitive behaviors, speech and nonverbal communication (Autism.org). Those with impaired communication skills need different methods, specifically terms used, to interact effectively. For example, neuroscientists might use words such as "healthy people" to differentiate between non-autistic and autistic groups. The term "healthy" implies that people with autism are unhealthy. A different choice of language may signal a different response, for instance, groups who argue for the acceptance of autism will use the word "difference," and those who argue for the cure to autism use the word "disorder".

In her article, *What are Neurorhetorics*, Jack explains that neurorhetoric is used by rhetoric scholars to "investigate the 'neural correlates' of rhetorical concepts such as

pathos, presence, identification, or persuasion" in order to better understand the audience and their impulse and response, while maintaining the significance of critical and rhetorical perspectives on discourses involving the brain (Jack 406). Neurorhetoric looks at neuroscience research to investigate viewpoints that can be achieved to design conversations in rhetoric and rhetorical theories.

The rhetoric of neuroscience investigates the ways in which the concepts of neuroscience are communicated within the neuroscientific community. In other words, it is the application of rhetoric to the field of neuroscience. Conversely, the neuroscience of rhetoric involves the application of neuroscience to the field of rhetoric. Daniel Gross in his article, *Toward a Rhetoric of Cognition,* discusses neurorhetoric by dividing it into two areas:

> 1) the rhetoric of neuroscience, which appears as a familiar subcategory of the rhetoric of science insofar as it examines the 'modes, effects, and implications of scientific discourse' such as the 2010 effort to brain-image 'yes' and 'no' (headline: "Vegetative patient 'talks' using brain waves"), and 2) the neuroscience of rhetoric, which uses neuroscientific research to reconsider familiar rhetorical issues in language, persuasion, and communication, such as the relationship between pathos and logos, or to explore new territory such as physiological questions about how brain differences might influence communication (Gross 53).

As demonstrated earlier, the typical suicidal soldier likely has a predisposition to not respond well to suicide intervention or seek help on his or her own. This

predisposition reflects a neurological reality acting as a barrier to being persuaded to take positive steps towards the healing process. The concept of neurorhetoric potentially offers solutions within the same neurological medium as the source of the problem; thus, neurorhetoric should warrant an important role in establishing suicide prevention training.

3.3 Brain Culture: Rhetorical Brain

Aligned with the concept of neurorhetoric, Davi Johnson Thornton wrote a book, *Brain Culture: Neuroscience and Popular*, on the "rhetorical brain" which describes the unique ways to theorize the brain in contemporary culture. Its visual characteristics are crucial to the ways the brain is understood, and explains the influence of society on the brain and its rhetorical ways that shape our brain (Thornton 62). Rhetorical brain is a study of brain science at the level of culture, in terms of its impact on the practices of everyday life. A key feature of the concept of the rhetorical brain is that it's based on brain images that could support claims about the role of the brain as both cause and effect (55).

The theory supports reports that willful efforts can have an immediate, visible effect on brain function. In these contexts, brain images are put to dual uses – they are often used to substantiate biological determinism ("your brain is responsible for everything you do"), but they are also deployed to support claims that emphasize individual agency and responsibility ("you must take specific actions to guarantee the health of your brain") (65).

Thus, the "rhetorical brain" is impacted by society in various ways – images, concepts, self-help books, museums, magazines, movies, news – all rhetorically shape

our brain. Rhetoric is used as a tool in many ways in our society, whether in an advertising campaign or a well-prepared sales presentation. By the same token it should be incorporated into Army suicide training in ways that will re-shape soldier's brains to overcome difficulties and lessen the stigma of suicide in the Army such that soldiers will be more likely to seek help.

Figure 4: The New Map of the Brain (Kluger)

Brain training manuals have been created based on the map of the brain to help readers to pursue better brains by "intervening at the level of process to balance, slow down, speed up, intensify, or dampen activity levels" (301). Likewise, ads for antidepressants and other psychotropic medications promise to "stabilize" or "balance" chemicals as they advance through the sections of the brain. Functional brain images and their accompanying languages suggest that brain activity, and hence life, is precarious – its continuity depends on an optimal balance and pace of activity, and it is constantly threatened by disruptive influences (302).

Therefore those hoping to improve their brain do so by reading self-help books, playing "brain training" video games, attending therapy or workshops, and the like. Hence, people are not mainly "governed"[3] through force or duress but through rhetorical ways, "or the dissemination of attractive, useful discourses that channel individuals' attitudes and behaviors in ways that converge with other interests" (151).

While neurorhetoric deals with the physical and chemical realities involved with communication, the rhetorical brain sheds light on the importance of behavior, habit, and culture as influencers to brain health. Both concepts help us to choose better words and use them in more effective ways in communicating with soldiers.

3.4 Identification: A Rhetoric of Motives

"You persuade a man only insofar as you can talk his language by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his."

– Kenneth Burke

So far we reviewed concepts of neurorhetoric and the rhetorical brain which help us to better understand ways that words connect in the brain, stimulate thoughts/beliefs, and how society uses rhetorical concepts to influence our brains. These two concepts can have a powerful impact during Army suicide prevention training if combined with Kenneth Burke's identification model. The trainer/speaker needs to connect with the audience/soldiers through this concept of identification in order for soldiers to be persuaded by the training. The concept of identification is the emotional connection that

[3] Thornton explains that Foucault created the notion of "governmentality," which refers to the ways in which individuals come to regulate themselves in the name of their own good (health, happiness, wealth) in the apparent absence of direct control by either the state or other powerful interests such as corporations (Thornton 143).

needs to be established in order for language and words to have meaning; identification connects emotions and brains together.

Burke suggest that for persuasion to happen, one party must "identify" with another. He explains that a speaker persuades an audience by the use of identification; for the purpose of causing the audience to identify itself with the speaker's interests; and the speaker draws on “identification of interests” to establish rapport between him/herself and the audience (Burke 46).

Burke asks readers to imagine two subjects; “Subject A” and “Subject B.” Subject A is not identical to Subject B, but if their interests are joined, Subject A is identified with Subject B. Burke states that A is “substantially one” with B. Subject A and Subject B remain individuals, but they have common interests. This means Subject A and Subject B live separate lives and may have different viewpoints about life, social issues or politics, but they can come together to work toward a common goal. Divisions occur because human beings are born and exist separately, but they seek to identify with others through communication. From a contemporary perspective, Burke sees human interaction as more complex than the term “persuasion” suggests. Identification is a process necessary to human communication. Burke states that we are “both joined and separate, at once a distinct substance and consubstantial with one another” (Burke 21).

Burke’s primary interest in identification is an appeal to speaker’s pathos as discussed in Aristotle’s Rhetoric. From Burke’s perspective, communication is a means for establishing and maintaining a social life. This is an aspect of persuading without considering one’s own benefit by placing yourself in the other person’s position and

considering their well-being. “Identification” can also be considered having empathy, “the ability to imagine oneself in another’s place and understand the other’s feelings, desires, ideas, and actions” as Jack and Appelbaum define in their article (419).

So in order to persuade a target audience, the speaker must connect with that audience at some point. This connection can be reached through “identification” and “empathy”, creating a rhetorical sense of community or feeling of responsibility. “Identification” is a key concept that could prove useful in developing Army training for suicide awareness both from the standpoint of making sure the training uses tools to identify with the training audience, and within the training material by teaching soldiers how to have empathy to have a deeper connection with potentially suicidal soldiers.

Since Aristotle, rhetoricians have been fascinated with the function of the brain and the ways language can influence the mind to better health and behavior. Many have studied the relationship between words, emotions, and behaviors, and discovered that many unpleasant or undesirable behaviors and emotions can actually be influenced for good by the proper selection of words. Overall, rhetoricians seek to use language to help people to live better, believing that language has direct access and impact on core thinking, emotions, and resultant behaviors.

In the next chapter, I’m going to bring the concepts discussed above to analyze ACE and to discuss ways these concepts can be useful in developing suicide prevention training. By creating methods or stimuli that will change the way soldiers think or view their lives, the training could work in a more persuasive way to make soldiers believe life is worth living and suicide is not a viable option.

Chapter 4: Incorporating Rhetoric into the Training

The effects of suicide go beyond the person who acts to take his/her life; it can have a lasting effect on family, friends, and communities. Here is Meaghan Smith's story on her brother's suicide posted on NYC Veterans Alliance website. Meaghan's story points out the complexity of suicide and challenges of recognizing the signs and reaching out to the individual.

> ***SUICIDE PREVENTION MONTH: LESSONS FROM A LOSS SURVIVOR***
> *By: Meaghan Smith*
>
> *Since my brother, Mike's service-related suicide in October 2010, I've experienced many an awkward pause when the inevitable, "what does your brother do now?" question comes up. September being Suicide Prevention Awareness Month doesn't diminish those awkward pauses, nor does it make it all of a sudden any easier to talk about suicide. It's a difficult topic that many Americans feel ill-equipped to discuss.*
>
> *This is the time of year we see a surge in social media posts on suicide prevention, where well-intended people offer themselves as "a port in the storm," or challenging others, "I bet not one of my friends will copy/paste this message" about suicide prevention resources. Others link to vital resources available to those in crisis and ways that family and friends can keep an eye out for signs and help those in need. These are all important to spread awareness, yet 20 veterans still die by suicide every day and 44,193 Americans die by suicide each year. It's as if we–the* ***"unaffected"–expect the signs that our loved ones are struggling with will be visible. We assume there will be one or more cries for help. We assume there will be a marked difference in our loved one's behavior.***

It's true that there are warning signs and signals– in fact, The American Foundation for Suicide Prevention has a very helpful list of things to look out for. But when I go over the timeline leading to my brother's death, ***I see a hundred signs we caught and a hundred more we missed****.*

When Mike came home from Iraq, there were a lot of things going on in his life that increased stress, which caused us concern. He was drinking more than usual. He had a shorter temper and his memory was spotty. He had a decrease in appetite. But he'd also just gotten back from war and we wanted to give him space to readjust to life at home on his own timeline. We were trying to be understanding and to show empathy for experiences we would never share.

Not that we didn't talk to him about it. ***We asked how he was doing. We told him we were there for him if he needed it.*** *He had been honest with some of what he saw in Iraq (he was in Ramadi and Fallujah) and* ***we offered to talk it through if needed.*** *He swore* ***he was fine****, even when we pushed a bit harder than usual. He famously told my father after one such questioning, "Hey Old Man, not to worry, I got this s**t covered!"*

*And he did seem to have that s**t covered. He proactively went to get treatment at the VA, where he'd sometimes wait for hours until the doctor could meet with him. He was pursuing a career in social work so he could help other veterans with their transition. He helped his fellow Marines when they were on the brink and battling their own suicidal thoughts. "He's the last person who would do this," they said.*

But on October 8, 2010, my mother called to tell me he was gone.
What I've learned through my family's experience, as well as from relationships I've been fortunate to forge with other suicide loss survivors over the last seven years, is that it's too easy to rationalize away the warning signs of suicide. It's just as easy to miss, hide or explain away red flags as it is to be in denial that a partner is being unfaithful, a parent is sick or a friend has a substance abuse problem, despite the overwhelming evidence.

What I've also learned is that while awareness is very important, it is also just the start of what's needed to save lives. Helping those in times of crisis needs to start before they're in crisis. It's going to require difficult one-on-one conversations. It's probably going to get messy and your loved one will potentially get annoyed with you.

It requires that we, the loved ones, walk a fine line between hypervigilance and enabling concerning behavior. We can't find ourselves inadvertently romanticizing the stories of those who commit suicide, but we also can't avoid it and treat it like dirty little secret either.

It's not easy. Despite losing my brother, it's still difficult for me to talk about suicide with people I don't know. When I'm concerned about a loved one, I still have that voice in my head that says, "Don't push it. They're just having a hard time. Give them a little bit to get their feet back under them."

If I can dare to speak on behalf of my survivor friends, I'd say that many of our loved ones seemed to be dealing with it--until they weren't. I think it's safe to say we would all be willing to risk them being frustrated with us if it meant we would still have them with us today.

So, share the resources and status messages on social media. We absolutely must ALL be more aware of the signs and how to get people help. But back that up with real and personalized action. Call your loved ones and don't let them off the hook when your gut is telling you something's wrong. Volunteer your services with organizations offering counseling. Find local groups, like the NYC Veterans Alliance, that are connecting servicemembers with the help they need.

Your loved one is fighting a courageous battle in their head. Match their courage and don't be afraid to show that you'll fight it right alongside them.

I share this story because as Meaghan points out there are warning signs that indicate suicidal tendencies but also there are "hundred more missed" signs. Even with seeing the signs, knowing and feeling the person's pain, talking to them is not an easy task. As we can see in Meaghan's story, confusion exists as to where to draw the line between helping and being too pushy or invasive. How does one know when the phrase, "I am fine," is real? Meaghan's story demonstrates why the ACE training is not the most effective training.

A report based on a study of *Barriers to initiating and continuing mental health treatment among soldiers*, conducted by the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), indicates that "the most frequently reported reason

for not seeking treatment among soldiers with perceived need was the desire to handle the problem on one's own (77.0%)" (Naifeh et al. 6). The study reveals that:

> 69.8% of never-treated soldiers reported no perceived need. Attitudinal reasons were cited more frequently than structural reasons among never-treated soldiers with perceived need (80.7% vs. 62.7%) and those who discontinued treatment (71.0% vs. 37.8%). Multivariate associations with socio-demographic, Army career, and mental health predictors varied across barrier categories. These findings suggest most soldiers with mental disorders do not believe they need treatment, and those who do typically face multiple attitudinal and, to a lesser extent, structural barriers (Naifeh et al. 2).

Meaghan's story corroborates the result of the study by the Army STARRS that most soldiers "desire to handle the problem on [their] own." (Naifeh et al. 5) or as Meaghan's brother told her father, "Hey Old Man, not to worry, I got this s**t covered!"

This is the reason that rhetoric becomes an important part of the training, in finding ways to connect emotionally with the audience (a suicidal person) and to be able to persuade them to seek help by choosing the appropriate language that will have a positive impact on the person's brain. Aristotle teaches us that there are three kinds of persuasion modes: ethos (character), pathos (emotion), and logos (logic). These elements of rhetoric along with the concepts of neurorhetoric, rhetorical brain, and identification can shape more valuable training that may succeed in reducing the rate of suicide and motivate soldiers to take step toward getting help with whatever is causing them so much emotional pain that suicide becomes an option. In this section, I analyze ACE training

through the rhetorical concepts of ethos & neurorhetoric, logos & rhetorical brain, and pathos & identification.

4.1 Ethos & Neurorhetoric

First, we need to fix the language used in ACE training based on ethos & neurorhetoric, making sure the chosen words are not sending negative or wrong signals to the audience/soldiers. Ethos encompasses the obligation of the speaker toward the audience. Neurorhetoric tells us about ways that words connect in the brain and stimulate thoughts and beliefs. In the study of autism, we learned that neurorhetoric can bring awareness in use of language, persuasion, and communication. Jack and Appelbaum used the word “healthy” in the case of autism to explain a word can have different meanings to different people with different mindsets, for example to people with autism it may imply that they are unhealthy. Jack and Appelbaum suggested that different choices of language may signal different responses.

In the Army suicide prevention training the speaker has the obligation to understand the audience and to know the impact of words such as mental illness, PTSD, or emotional distress on them. As discussed above, the stigma of mental illness can make words such as “mental illness,” “PTSD,” and “emotional distress” correlate with weakness and flaw. So according to neurorhetoric, using these words may have a negative impact on an audience of soldiers, causing them to shut down during the training and cut off opportunities for persuasion.

It is important to consider the role of rhetoric in communication, therefore, as Jack and Appelbaum suggest, providing the proper language is the key. For example,

maybe the word “overwhelmed” would have a less negative impact while communicating empathy and understanding. In a bigger context, let’s review and analyze first two slides of ACE training that are taken from the Army G-1 website:

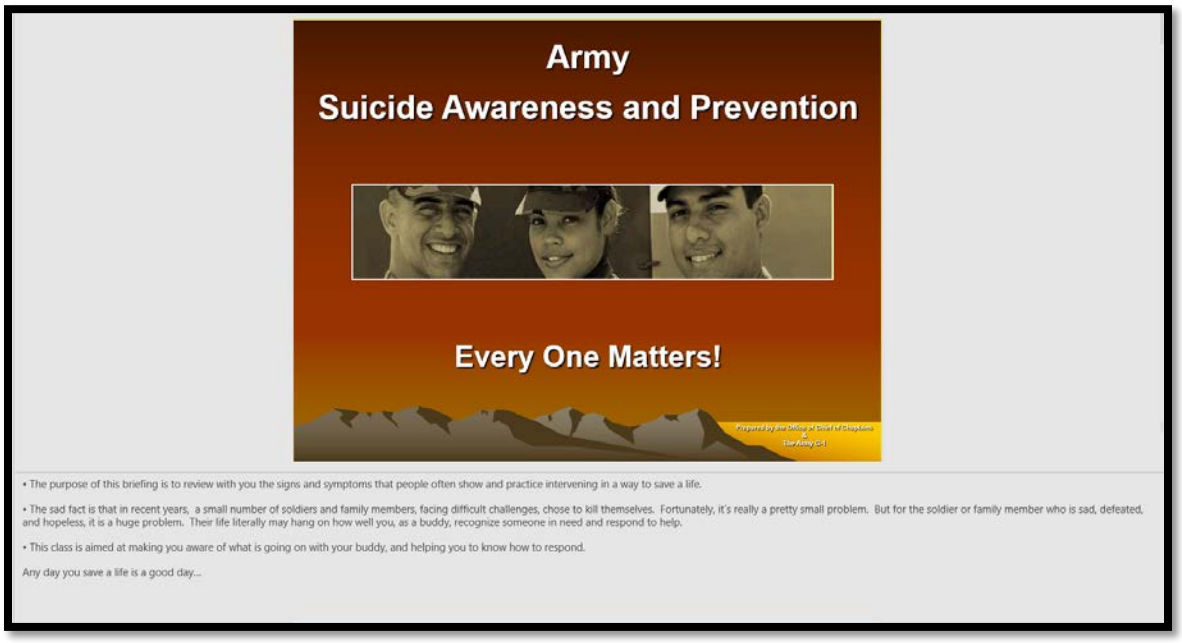

Figure 5: Army ACE Training, Introduction Slide (Army G-1, Army Suicide Prevention Program)

The notes for the introduction slide say:

- The purpose of this briefing is to review with you the signs and symptoms that people often show and practice intervening in a way to save a life.
- The sad fact is that in recent years, **a small number** of soldiers and family members, facing difficult challenges, chose to kill themselves. Fortunately, it’s really a **pretty small problem**. But for the soldier or

family member who is **sad, defeated, and hopeless**, it is a huge problem. Their life literally may hang on how well you, as a buddy, recognize someone in need and respond to help.

- This class is aimed at making you aware of what is going on with your buddy, and helping you to know how to respond. Any day you save a life is a good day.

This introduction not only fails to capture the audience's attention, it doesn't even indicate the importance of suicide and its prevention. The comment, "[t]he sad fact is that in recent years, a small number of soldiers and family members, facing difficult challenges, chose to kill themselves. Fortunately, it's really a pretty small problem" uses terms such as "small number" and "small problem" which send the message that one or two lives don't matter, and suicide is not important. A possible improvement would be for the training to include the current statistics on suicide to add emphasis on the importance of the issue and to urge soldiers to pay attention. Providing statistics also tells the soldiers that they are not the only one who might be experiencing a degree of mental distress, and it might help to communicate that something like PTSD and related symptoms are common for military personnel.

Additionally, aligned with the neurorhetoric concept of use of language and words, the training can replace the words "sad," "defeated," and "hopeless" with something like "overwhelmed," which means buried and drowned beneath a huge mass. The term "overwhelmed" tells the soldier, we understand and know you have too much to deal with, but you may need help to relieve some of the burden. The word

"overwhelmed" is commonly used for various degree of stress; it indicates that this is a situation that could happen to anyone, and it's not viewed as a weakness.

Next, I will examine the second slide that talks about the mission of the training.

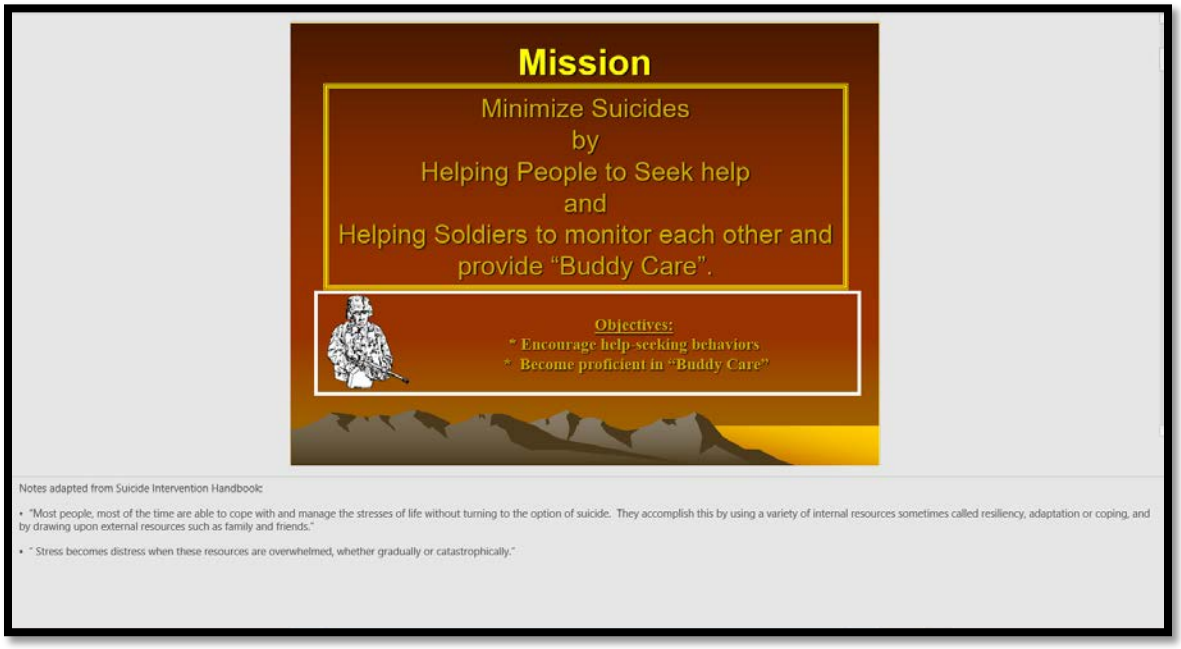

Figure 6: Army ACE Training, Mission Slide (Army G-1, Army Suicide Prevention Program)

The notes for this slide are taken from Suicide Intervention Handbook as indicated on the slide above:

- Most people, most of the time are able to cope with and manage the stresses of life without turning to the option of suicide. They accomplish this by using a variety of internal resources sometimes called resiliency, adaptation or coping, and by drawing upon external resources such as family and friends.

- Stress becomes distress when these resources are overwhelmed, whether gradually or catastrophically.

This slide and its accompanying notes have two problems. First, the message of the slide itself is vague and potentially counterproductive. The notes start with the idea that “most people, most of the time are able to cope”. Given that a soldier is trained to be strong and resilient, this particular choice of words could trigger or reinforce a motivation to handle the problem themselves and not seek help as the rest of the words suggest. The second problem with this slide is that it misses an opportunity to be more persuasive by having a stronger mission statement, perhaps something aligned with Department of Defense Mission Statement with regard to suicide prevention:

> Every suicide is a tragic loss to our nation and those impacted. The family and friends left behind who must deal with the aftermath of the event and put those events in perspective may, in some cases, never know why the service member or veteran took their life. Suicide is the culmination of complex interactions between biological, social, economic, cultural and psychological factors operating at the individual, community and societal levels. We are committed to fostering collaboration and cooperation to develop suicide prevention efforts Defense Suicide Prevention Office.

The Department of Defense Mission Statement uses a language that expresses the importance of the issue of suicide. It states the complexity of suicide, and tells the audience that they are committed in taking actions toward resolving the issue. This is a

mission statement that will capture the audience's attention, and it can possibly persuade them to join in and help to prevent suicide.

4.2 Logos & Rhetorical Brain

In addition to addressing the above elements of the language used in ACE training, appeals to logos might also aid in persuasiveness of our discussion. Soldiers need to know: why are they receiving this training? What causes suicidal thoughts? What are their options? How they can overcome stigma? Logos is the appeal towards logical reason, thus the speaker wants to present an argument that appears to be sound to the audience. It encompasses the content and arguments of the speech. Like ethos and pathos, the aim is to create a persuasive effect; thus, the apparent is sufficient:

Brain scans and imaging can be given to discover how the brain is impacted by words. Brain mapping enables discussion of the brain and how it works as a neurochemical machine that can help individuals understand themselves more like a car that has a broken part that needs to be replaced or that needs an oil change, which helps to de-emotionalize and de-stigmatize suicidal thoughts. This concept can be incorporated into the training providing logos or logic the soldiers need in order to be persuaded.

Better understanding of how the brain works allows for better, more practical steps to resolve. This can be added to the training, to allow soldiers to understand symptoms and self-recognize when something is wrong as well as to understand that practical solutions are available.

Additionally, Thornton talks about the influence of society on the brain and its rhetorical ways that shape our brain. This creates a neural pathway that is problem-

solution oriented and associates that with suicidal thoughts, which might help to counteract the stigma pathways that might exist.

For example, in Chapter 2 here, we talked about the stigma of mental illness in the Army. Figure 2 illustrates the slide on the issue of stigma that is provided during ACE suicide prevention training. Stigma is a major issue that prevents soldiers from seeking help, a slide on this subject matter should cover whole lot more in order to convince soldiers that their career and reputation will be protected if they choose to seek medical help. This can be done by providing information similar to Matthew Tull's article, *reducing the Stigma of Mental Health Care in Veterans*:

> [T]o limit fear that the report of psychological difficulties will negatively impact security clearance, the Department of Defense no longer requires people to report if they have sought out mental health care for combat-related reasons. In addition, high-ranking military personnel are sharing their experiences with PTSD and the treatment they received. The Department of Defense is also attempting to convey that the experience of stress as a result of combat-related experiences is normal. Finally, the Department of Defense launched an anti-stigma campaign called the *Real Warriors Campaign*. This campaign is designed to promote resilience, recovery, and support for returning service members, veterans, and their families (Tull).

This information helps soldiers to better understand that 1) mental and emotional stress/illness is common in their line of work and it can happen to anyone, including

high-ranking military personnel, 2) their information will be confidential and will not jeopardize their career, and 3) they have options such as the *Real Warriors Campaign.*

4.3 Pathos & Identification

Lastly, the speaker/trainer needs to connect with the audience/soldiers at an emotional level by using the concept of identification. Soldiers need to know and understand that the information/training they are receiving is provided by a trusted source who can relate to them and their stressors, perhaps someone who has been in a combat zone or someone who has overcome suicidal tendencies. The goal of each speech is to persuade the audience; therefore, it is necessary to put the audience in the appropriate emotional state.

As we discussed earlier, Burke's primary interest in identification is an appeal to speaker's pathos. In order to persuade a target audience, the speaker must connect with that audience at some point. This connection can be reached through "identification" and "empathy", creating a rhetorical sense of community or feeling of responsibility.

The aim of pathos is to reduce the audience's ability to judge. One possibility to achieve this is through the correct use of figures of speech. These figures can be used to put certain content and arguments in fore- or background. This allows the speaker to increase the effectiveness of the delivery, by either underlining the strong parts or minimize the weak parts.

The Army suicide prevention training needs to choose trainers/speakers who can identify with soldiers. According to Army Regulation (AR) 600-63, Army Health promotion, the Army Suicide Intervention Training is managed and provided by

"gatekeepers," which are broken down to two categories: Primary & Secondary (AR 600-63, Table 4-1, 19).

Table 4–1
Gatekeepers

Primary Gatekeepers	Secondary Gatekeepers
Chaplains & Chaplain Assistants	Military Police
ASAP Counselors	Trial Defense and Legal Assistance Attorneys
Family Advocacy Program Workers	Inspectors General
Army Emergency Relief Counselors	DOD School Counselors
Emergency Room Medical Technicians	Red Cross Workers
Medical/Dental Health Professionals	

Table 2: Table 4-1 Gatekeepers (AR 600-63*)*

While these gatekeepers meet all the criteria of ethos by virtue of their position and responsibilities, they mostly lack the aspect of identification or pathos. This stems from the fact that the training for thousands of soldiers is usually performed by a few individuals who cannot hope to have developed relationships of any real depth with all of the individuals across the base. In addition, for the suicidal individual in the audience, there is no guarantee that the speaker has any personal experience with suicidal struggles or close friends of family with such experiences which would go a long way towards identification. There is little doubt that these gatekeepers sympathize with soldiers and are fully capable of recognizing those who suffer from stress and mental illness, nevertheless they are often strangers to soldiers or lack close personal ties and likely have no linkage through personal experience with suicidal struggles either.

One way to resolve the issue is by providing training in smaller groups, preferably within the section, platoon, or squad to which soldiers are assigned by their first line leader or senior leader. The small group sessions can be beneficial in many ways:

- it creates a safe intimate environment for soldiers to connect and bond with each other,
- it can create an opportunity for leaders to better know their soldier, it gives leaders a chance to show they care and communicate one-on-one,
- it can establish a prospect for soldiers to open up and discuss their issues or even ask for help,
- it will eliminate the fear of being judged by strangers (in a large groups, the likelihood of people knowing each other is much lower), and
- it can be tailored based on occupation, gender, or age which can help to overcome some of the complexity of suicide as we discussed in Chapter 1.

The above examples are just a very few ways that the Army suicide prevention training can improve. It is as simple as changing some language and creating a semi confidential/private environment with trusted instructors in order to create a more effective training curriculum. This is the essence of rhetoric, using all means to persuade the audience to act as the speaker wants them to.

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Chapter 5: Conclusion

ACE comes out of a conception of the brain and emotion as physical objects that can be manipulated. But, a rhetorical perspective or neurorhetoric offers a different perspective on persuasiveness and how people can identify and reach out to people in mental health crisis.

Records shows that Army Suicide Prevention/Intervention is not effective mainly because soldiers like to handle the situation on their own, don't perceive a need for help, or have attitudinal barriers to seeking treatment. The training is not convincing enough to persuade the soldier to admit they have a problem, to overcome the stigma, and to seek help (Naifeh et al. 4). The ACE Intervention Training fails to make soldiers believe they are in charge of their own destiny and that they can overcome mental illness, depression, and all other stressors that causes them pain and suffering.

The concepts discussed in this thesis can assist those who prepare and provide the Army suicide prevention training to understand their audience (soldiers) better in order to be able to prepare and provide more persuasive training. We can use Jordynn Jack's neurorhetoric, the study of neuroscience and rhetoric to better understand ways that words connect in the brain and stimulate thoughts and beliefs. Davi Thornton's Brain Culture (Rhetorical Brain), explains the influence of society on the brain and its rhetorical ways that shape our brain. Lastly, Kenneth Burke's identification concept states that in

order to persuade effectively, one must relate or show empathy. These concepts all provide tools that can help us to find different methods and approaches of reaching out to soldiers to persuade them to consider options other than suicide.

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Biography

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