

High Suicide Rates among United States Service Members and Veterans of the Post-9/11 Wars

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Summary

Suicide rates among the United States public have been increasing for the past twenty years, but among active military personnel and veterans of the post-9/11 wars, the suicide rate is even higher, outpacing average Americans. The “post-9/11 wars” refers to ongoing U.S.-led military operations around the world that grew out of President George W. Bush's "Global War on Terror" and the U.S. invasion of Afghanistan in 2001. **This paper estimates 30,177 active duty personnel and veterans of the post 9/11 wars have died by suicide, significantly more than the 7,057 service members killed in post-9/11 war operations.** These high suicide rates are caused by multiple factors, some inherent to fighting in a war and others unique to America’s “war on terror” framework. Partially, they are due to risks common to fighting any war: high exposure to trauma, stress, military culture and training, continued access to guns, and the difficulty of reintegrating into civilian life. In the post-9/11 era, the rise of improvised explosive devices (IED), the attendant rise in traumatic brain injuries (TBI), the war’s protracted length, advances in medical treatment that keep service members in the military longer, and the American public’s disinterest in the post-9/11 wars, have greatly contributed to increased suicide rates. High suicide rates mark the failure of the U.S. government and U.S. society to manage the mental health costs of our current conflicts.

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Introduction²

Army Sergeant Dominic McDaniel was a forward observer in the Infantry Division for seven years.³ As a “sister” or “FiSTer,” his job was to “remain as calm as possible and drop accurate bombs on enemy target locations,” using his expertise in land navigation and logistics to ensure the safety of his fellow infantrymen. While technically in a support role, he often found himself deep in the combat zone on foot with light infantry, looking for enemy combatants. In 2005, he advanced to squad leader in Sadr City, Iraq, with a group of young soldiers now in his care. In “an extremely bloody time,” McDaniel felt it was his job to keep them safe.

When members of his squad – including the youngest member of his battalion – were wounded in combat, he felt immeasurable guilt. McDaniel recalled, “A couple guys got hurt, and essentially I prayed, and I asked God for help. And at the end of that, I felt that no one was coming, and it was up to us. And that was a very alone, isolating feeling for sure, and I don’t know if that went away after that.”

An IED explosion left McDaniel with physical and mental wounds that eventually forced him to resign after a pre-deployment assessment “flagged” him as unfit for combat with a combined traumatic brain injury (TBI) and PTSD diagnosis. The Army told him to put in his disability claim, and just like that, his military career ended. McDaniel’s transition back to civilian life was a terrible time. “I isolated. I felt guilty because my guys got hurt, and I was in charge,” he said. “It was my fault. They started committing suicide when we got home pretty quick.”

Medically discharged, the loss of his brothers in arms and his overwhelming guilt led to alcohol abuse, divorce, and a feeling of “cascading betrayal.” At his lowest, Sgt. McDaniel, fortunately, found useful resources for depression and suicidal ideation. Unfortunately, many of those in his battalion could not continue to cope with their traumas. He revealed that while his unit lost nine people in Iraq, 15 have taken their own lives since leaving the service. “Now more people from my unit have committed suicide than died in combat,” he said. “I feel that because of that, it made me reflect on what we went through, where we were at, how our role in the war has caused some of this extreme chaos in the minds of fellow soldiers. ... It really kind of strips your humanity and soul away, war does.”

Army Sergeant McDaniel now works for a nonprofit helping other veterans who have experienced severe trauma in peer-to-peer settings. He spends his time counseling veterans who, as he once did, struggle with personal crises and feelings of hopelessness.

² At the outset, I wish to note this article focuses at length on the ways service members and veterans face hardship and mental illness that may lead to suicide. The veterans emphasized here represent an alarming and significant portion but non-majority of service members and veterans. I do not wish to reinforce stereotypes of veterans that mark them as *prima facie* broken or dangerous people.

³ Quoted veterans in this article participated in an IRB-approved series of confidential interviews with the author. Each has been assigned a pseudonym for the purpose of confidentiality. None of the participants reported current or ongoing suicidal ideation or behaviors.

His experiences are not rare. Sgt. McDaniel’s experiences represent just one story of trauma, suicidal thoughts, and a now persistent feature of military life — losing fellow service members to suicide.⁴ In a recent survey of 1,705 veteran members of Iraq and Afghanistan Veterans of America (IAVA), 67 percent of veterans knew a post-9/11 veteran who had attempted suicide, and 62 percent knew a post-9/11 veteran who successfully committed suicide.⁵ In fact, as this paper shows, since 2012, suicide rates for active duty service members and veterans have outpaced those of combat deaths in post-9/11 conflicts. **An estimated 30,177 active duty service members and war veterans of the post 9/11 wars have died by suicide, significantly more than the 7,057 killed in “Global War on Terror” military operations. This marks a failure by the military and U.S. society to manage the mental health cost of our current conflicts.**⁶ This paper will discuss these rates in depth below.

This trend is deeply alarming. The increasing rates of suicide for both veterans and active duty personnel are outpacing those of the general population, marking a significant shift. Historically, suicide rates among active component service members have been lower than suicide rates among civilians. Elizabeth P. Van Winkle, the U.S. Department of Defense’s (DoD) Executive Director of Force Resiliency, explained, “suicide rates for active-component and reserve members [were] comparable to U.S. population rates after accounting for age and sex.”⁷ The DoD reiterates that point in its annual suicide reports; however, the current rate has increased to meet the age-adjusted civilian suicide rate and has now surpassed it. That the current rate is commensurate with the civilian rate after historically being far lower ought to raise concerns. Meanwhile, suicide rates among post-9/11 war veterans surpass civilian rates. The growing crisis is especially pressing because veterans of post-9/11 conflicts are disproportionately dying by suicide compared to previous military service eras.

There are clear contributors to suicidal ideation like high exposure to trauma – mental, physical, moral, and sexual – stress and burnout, the influence of the military’s hegemonic masculine culture, continued access to guns, and the difficulty of reintegrating into civilian life. In addition to these factors, it is imperative we also consider the impact of the military’s reliance on guiding principles which overburden individual service members with moral responsibility, or blameworthiness for actions or consequences, over which they have little control.

⁴ The veterans and military personnel discussed in this report represent different branches of the military. I will refer to the active military component as “service members” to encapsulate all Soldiers, Marines, Sailors, Airmen, National Guardsmen, etc.

⁵ Britch, Ryan. (2020). *10th Annual IAVA Member Survey: Perceptions and Views of Iraq and Afghanistan Veterans on the Challenges and Successes of the Next Greatest Generation of Veterans* (Report). Iraq and Afghanistan Veterans of America (IAVA). <https://iava.org/survey2020/IAVA-2020-Member-Survey.pdf>

⁶ U.S. Department of Defense. (2021). *Casualty Status as of 10 a.m. EDT May 10, 2021*. <https://www.defense.gov/casualty.pdf>

⁷ Lopez, C. T. (2019, September 26). *DOD Releases Report on Suicide Among Troops, Military Family Members*. U.S. Department of Defense. <https://www.defense.gov/Explore/News/Article/Article/1972793/dod-releases-report-on-suicide-among-troops-military-family-members/>

If the above factors are likely true of all wars, we must also examine unique elements of the U.S. post-9/11 wars that may have led to what many have called a “suicide epidemic.”⁸ For example, since the post-9/11 wars began, we have seen a tremendous rise of improvised explosive devices (IEDs) in warfare, significantly increasing the number of traumatic brain injuries (TBIs) and polytrauma cases among service members.⁹ TBIs have affected as many as 20 percent of post-9/11 service members, with many experiencing more than one during their career.¹⁰ Simultaneously, the length of the war and advances in medical care have allowed service members to redeploy after severe physical trauma. These compounding traumas contribute to worsening suicide rates as service members deploy and redeploy after sustaining severe injuries. Together, these and other factors may account for current veteran and active duty suicide rates.

As we come closer to the twentieth anniversary of the September 11th attacks, we must reflect on the mental health cost of the Global War on Terror. The human cost for our veterans and service members far outweighs even the most crippling financial costs we have endured to send them to war.

Many studies have attempted to understand the causes of suicide in the military. Nevertheless, “the precise cause of the increase in military suicides remains unknown.”¹¹ This paper explores possible causes using currently available data from the DoD, the V.A., and related institutions to determine rates and numbers with as much consistency as possible. The paper also draws on secondary literature that provides analyses and insights from numerous related investigations. Finally, this paper relies on a series of semi-structured qualitative interviews conducted by the author about the role of faith and morality in the lives of post-9/11 service members and war veterans before, during, and after their military careers.¹² These interviews included stories of triumph and trauma from those in every branch of service. While some left the military unscathed, most have had to confront the difficulties of military experience. As one sailor reflected, “Anytime you are involved in the military, you are connected to something that is constantly doing both

⁸ Pilkington, E. (2013, February 1). US Military Struggling to Stop Suicide Epidemic among War Veterans. *The Guardian*. <https://www.theguardian.com/world/2013/feb/01/us-military-suicide-epidemic-veteran>

⁹ Polytrauma is a combination of significant secondary injuries (both mental and physical) in addition to a primary traumatic brain injury (TBI) usually stemming from blast-related events. This may include severe burns, spinal, auditory, or visual injuries, and post-traumatic stress disorder.

¹⁰ Bryan, C. J., & Clemans, T. A. (2013). Repetitive Traumatic Brain Injury, Psychological Symptoms, and Suicide Risk in a Clinical Sample of Deployed Military Personnel. *JAMA Psychiatry*, 70(7), 686-691.

¹¹ Castro, C. A., & Kintzle, S. (2014). Suicides in the Military: The Post-Modern Combat Veteran and the Hemingway Effect. *Current Psychiatry Reports*, 16(460), 1-9.

¹² The IRB-approved study included a self-selecting sample of veterans and service members who responded to public interest forms targeting those who served in the U.S. Armed Forces after the September 11th attacks and who once or currently identified as Christian. The latter requirement relates to part of the study dealing with the role of Christian faith in their lives, which has no significant bearing on this current paper. The interviews included 53 post-9/11 era service members and veterans, including six military chaplains. In total, 41 men, 11 women, and one gender-fluid individual participated, representing all branches, components, and both enlisted and officers.

ill and good. It's just inevitable. There is enough moral stain in the mix that, just by joining, you are going to come out stained."

Neither the qualitative interviews nor the secondary literature and data pointed to a singular cause for increased military suicides. There are simply too many variables that may contribute to rising rates. Moreover, the different roles of service members in the different branches and components (Active or Reserve) all present unique risk factors. An Air Force engineer would have quite a different experience from an infantryman in the Army, who would have a vastly different experience from a Navy reservist. A 2012 Armed Forces Health Surveillance Center report, for example, revealed suicide rates for the Army and the Marines were higher than those of the Navy and the Air Force.¹³ Attempting to identify the primary cause of increasing suicide rates would require piecing together a puzzle we can often only identify in hindsight with limited knowledge of the individual circumstances under which people chose to take their own lives. Still, it is worthwhile to lay out the patterns of factors affecting military personnel and veterans in our modern wars, as well as what factors may be unique to the post-9/11 era. Such an examination may allow us to grasp potential causes and, ultimately, lay the groundwork for solutions for combating the current epidemic of suicide.

Rates of Veteran and Active Component Service Member Suicides

The U.S. veteran suicide rate per 100,000 has outpaced that of the public and reveals an increasingly severe crisis. The VA 2020 National Veteran Suicide Prevention Annual Report reveals the suicide rate of veterans overall and adjusted for age and sex is 1.5 times that of the general population (See adjusted veteran rates versus the general population in Figure 1). This rate is likely a conservative one because, unlike earlier reports, the V.A. only counts veterans who were federally activated, leaving out Reservists and National Guardsmen who were not federally activated.¹⁴ One consequence of this change is that the oft-cited 21 veteran suicides per day figure is now about 17 per day.¹⁵ The current actual rate is 27.5 per 100,000, adjusting for age and sex and still absent Guardsmen and Reservists, meaning the rate has grown to be about 1.5 times worse since 2005. Additionally, of veterans ages 18 to 34, the rate has increased by 76 percent since 2005.¹⁶

¹³ O'Donnell, F. L. (Ed.). (2012a). Deaths by Suicide While on Active Duty, Active and Reserve Components, U.S. Armed Forces, 1998-2011. *Medical Surveillance Monthly Report*, 19(6), 7-10.

¹⁴ See, again, Office of Mental Health and Suicide Prevention. (2020), p.12.

¹⁵ For a comparison of numbers before the change in accounting with the 2019 report numbers, look at Kemp, J., & Bossarte, R. (2012). *Suicide Data Report, 2012* (Rep.). Department of Veterans Affairs Mental Health Services Suicide Prevention Program. <https://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf> versus Office of Mental Health and Suicide Prevention. (2019a). *2019 National Veteran Suicide Prevention Annual Report* (Report). US Department of Veterans Affairs. https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf.

¹⁶ See, again, Office of Mental Health and Suicide Prevention. (2020), p. 20-1.

While the suicide rate of the general population has also grown 1.3 times the 2005 rate, the increases are not commensurate with those of veterans overall and certainly not with more recent younger veterans of the post-9/11 wars.

In total, there were 89,100 confirmed U.S. veteran suicides between 2005 and 2018, including veterans of the Global War on Terror and also previous wars such as the Vietnam War.¹⁷ The VA began tracking suicide rates among veterans in the mid-2000s and has not released current rates or numbers beyond 2018 despite publishing annual reports since 2005. Estimating an average of 6,364 veteran suicide deaths per year, the total number between 2005 and the present day is likely closer to 95,460.

Most of today's veterans did not participate in post-9/11 conflicts; about 3.764 million veterans (21 percent of the more than 18.2 million veterans in the U.S. today) served after the September 11, 2001 attacks.¹⁸ If the percentage of veteran suicides were the same for post-9/11 veterans as for all veterans, then post-9/11 suicides might total 20,370. However, for various reasons, which this paper explores, suicide rates are much higher for post-9/11 veterans, particularly those in the 18-34 age group, rising from an average suicide rate of 32.3 per 100,000 between 2005-2017 to 45.9 per 100,000 in 2018.¹⁹ Therefore, we can conservatively estimate the number of suicides among Global War on Terror veterans to be about 22,261. Even at these conservative numbers, they are triple the 7,057 service members who have died during Global War on Terror operations.²⁰ Moreover, the current suicide rate of 45.9 among veterans 18-34 is about 2.5 times the suicide rate of that of the adjusted general population (18 per 100,000).²¹

The actual number of post-9/11 veterans who have died by suicide is likely higher than the V.A. records indicate. The difficulty in coming to the actual number stems from the V.A. not differentiating veteran suicides by their time of service, and they have inconsistently measured suicides since 2001 and have yet to report the actual number of post-9/11 veterans who have committed suicide. However, an exact number may itself be somewhat beside the point as it is the suicide rate per 100,000 that shows changes in the ongoing problem of veteran suicide.

¹⁷ See Office of Mental Health and Suicide Prevention. (2020). *2020 National Veteran Suicide Prevention Annual Report* (Report). U.S. Department of Veterans Affairs. <https://www.mentalhealth.va.gov/docs/data-sheets/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf>, p.16 for reported numbers.

¹⁸ Vespa, J. E. (2020, June). *Those Who Served: America's Veterans From World War II to the War on Terror - American Community Survey Report* (Rep. No. ACS-43). United States Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2020/demo/acs-43.pdf>

¹⁹ Derived from data provided by Office of Mental Health and Suicide Prevention. (2019b). 2005-2017 National Suicide Data Appendix [obtained from the joint VA/DoD Suicide Data Repository]. https://www.mentalhealth.va.gov/docs/data-sheets/2017/2005-2017_National_Data_Appendix.xlsx; also, see Office of Mental Health and Suicide Prevention. (2020), p.19, for most recent rate.

²⁰ Mann, C. T. (2019, April 18). *U.S. War Costs, Casualties, and Personnel Levels Since 9/11* (Rep. No. IF11182). Congressional Research Service. <https://fas.org/sgp/crs/natsec/IF11182.pdf>

²¹ Source: Rates reported in Office of Mental Health and Suicide Prevention (2020) and compared with 2017 Centers for Disease Control and Prevention Fatal Injury Data reported in National Institute of Mental Health. (2019). *Suicide* (Report). <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

The rate of active duty personnel suicides has also been called an “epidemic of soldier suicides.”²² The DoD tracks quarterly suicide rates for those currently active within the Air Force, Army, Marine Corps, and Navy. Much like the rates for veterans who have already returned to civilian life, active component service members have also experienced a significant increase in suicides per 100,000, although the trends between veteran and active duty suicides are not uniform.

The DoD and others have maintained, apart from 2012, the suicide rates adjusted for age, sex, and population are almost the same between active duty service members and those of the general population.²³ They can no longer argue this since the number of suicides and the rate have become worse in recent years as 2018, 2019, and 2020 have consecutively marked the worst years of active service member suicide since the previous peak year in 2012.²⁴ Rates of active component suicides decreased after the 2012 peak, but they have trended on an upward slope since the post-2012 valley. Those rates have now surpassed the 2012 rate and outpace the suicide rate of the public.²⁵

Even an observation that suicide rates of active duty service members are at or slightly above those of the general population is cause for alarm. The suicide mortality rate of active duty service members has historically been lower than that of the general population. Further, active duty suicide rates have decreased during wartime in every U.S. war besides Vietnam and the Global War on Terror.²⁶ Instead, rates of active duty suicide have been slowly increasing since at least 2004.²⁷ More importantly, as hostile combat deaths have gone down considerably since 2007, suicide rates continue to climb unabated (See adjusted active duty rates versus hostile death rates in Figure 1).

²² McDermott, J. (2012, August 1). Soldier Suicides, An Epidemic We Must Defeat. *TIME*.
<https://nation.time.com/2012/08/01/soldier-suicides-an-epidemic-we-must-defeat/>

²³ See Under Secretary of Defense for Personnel and Readiness (2019, September 13). *Annual Suicide Report - CY 2018* (Rep. No. D-30C1C14). Department of Defense.
https://www.dspo.mil/Portals/113/2018%20DoD%20Annual%20Suicide%20Report_FINAL_25%20SEP%2019_508c.pdf, p. 34. See also, Pruitt D., Smolenski, D. J., Bush, N. E., Tucker, J., Issa, F., Hoyt, T. V., & Reger, M. A. (2019). Suicide in the Military: Understanding Rates and Risk Factors Across the United States' Armed Forces. *Military Medicine*, 184(Suppl 1), 432-437.

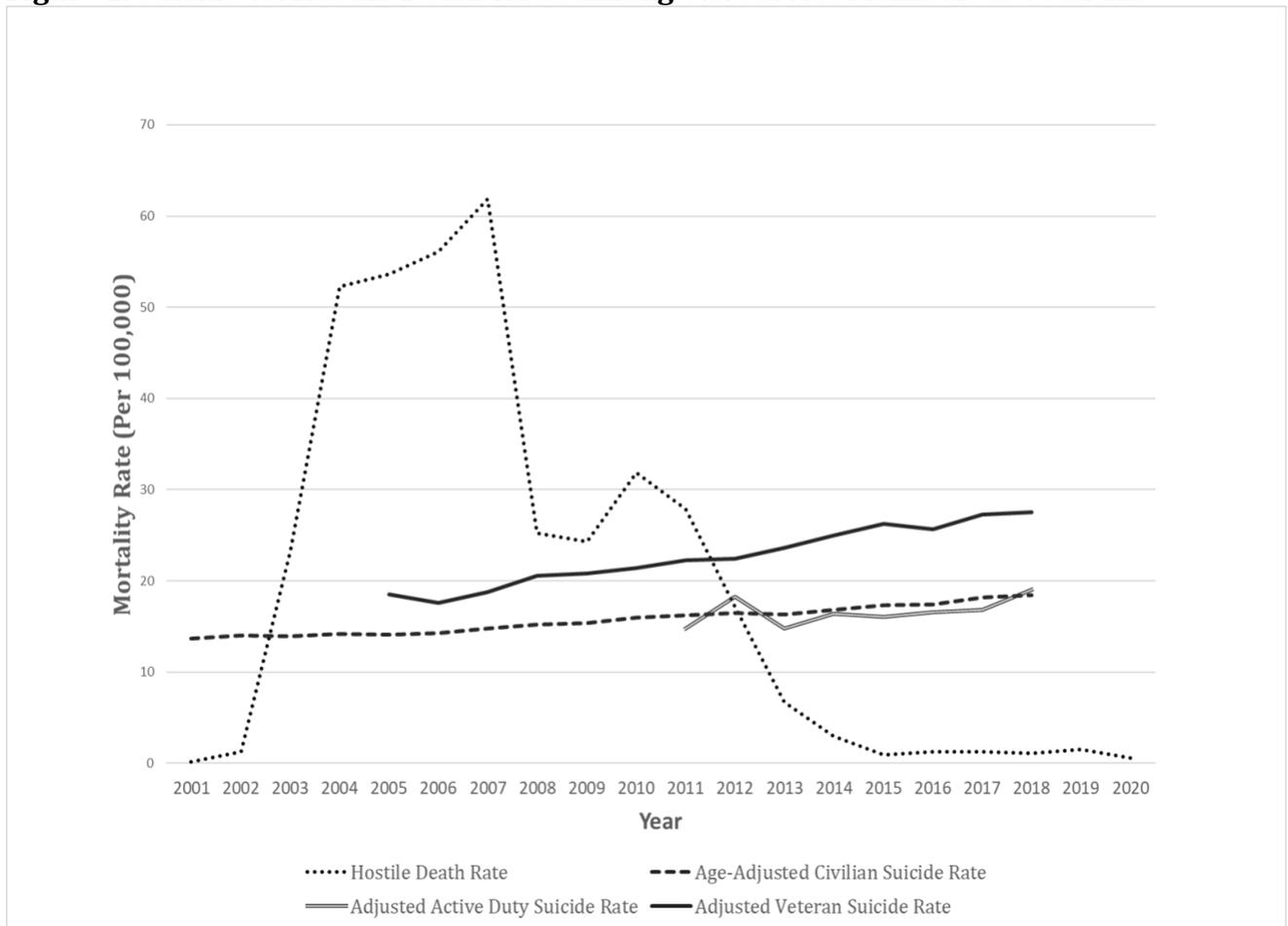
²⁴ Ibid. and Orvis, K. A. (2020). *Department of Defense (DoD) Quarterly Suicide Report (QSR) 4th Quarter, CY 2020*. Department of Defense: Defense Suicide Prevention Office.
https://www.dspo.mil/Portals/113/Documents/2020QSRs/TAB%20A_20210309_OFRRpt_Q4%20CY%2020%20QSR.pdf?ver=UKN194rEw5MhM_vaGy0j0w%3d%3d

²⁵ See, again, Under Secretary of Defense for Personnel and Readiness (2019, September 13).

²⁶ Smith, J. A., Doidge, M., Hanao, R., & Frueh, B. C. (2019). A Historical Examination of Military Records of US Army Suicide, 1819 to 2017. *JAMA Network Open*, 2(12), 1-11.

²⁷ See Pruitt et al. (2019) and Lineberry, T. W., & O'Connor, S. S. (2012). Suicide in the US Army. *Mayo Clinic Proceedings*, 87(9), 871-878.

Figure 1. Suicide vs. Hostile Death Rates among U.S. Service Members & Veterans²⁸



²⁸ This chart displays hostile death rates, as opposed to total combat deaths including hostile and non-hostile incidents, because this is the clearest comparison with suicides. The "total deaths" are measured inconsistently over time and between different conflicts. Sometimes they include "self-inflicted," sometimes they do not. Self-inflicted deaths may be accidents, or they could fall in an "unknown" cause category that could be suicide. Rates were determined using data provided by the Defense Casualty Analysis System, the Defense Manpower Data Center, the Centers for Disease Control and Prevention, the VA, and the DoD. See Defense Casualty Analysis System. (2012). *Active Duty Military Deaths by Year and Manner 1980 - 2010 (As of November 2011)*. U.S. Department of Defense.

https://dcas.dmdc.osd.mil/dcas/pages/report_by_year_manner.xhtml; Defense Casualty Analysis System. (2020). *Conflict Casualties*. U.S. Department of Defense.

<https://dcas.dmdc.osd.mil/dcas/pages/casualties.xhtml>; Defense Manpower Data Center. (2020). *DoD Personnel, Workforce Reports & Publications*. U.S. Department of Defense.

https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp; Centers for Disease Control and Prevention. (2020). *WISQARS Fatal Injury Data Visualization Tool*. <https://wisqars-viz.cdc.gov:8006/explore-data/home>; U.S.

Department of Veterans Affairs. (2018). 2005-2018 National Suicide Data Appendix. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2018/2005-2018-National-Data-Appendix_508.xlsx;

Defense Suicide Prevention Office. (2020). *DoDSEER Annual Reports*. U.S. Department of Defense.

<https://www.dspo.mil/DoDSEER/>; and data provided by the Defense Health Agency per a Department of Defense Suicide Event Report data request. See also, Defense Casualty Analysis System. (2012).

Rates and figures by the DoD and other sources may be prone to data error.²⁹ The reported rates may severely underreport the number of actual active duty suicides. A recent examination of reported suicide rates of active duty Army personnel also found “the Department of Defense Suicide Event Report details only approximately half of those who die by suicide.”³⁰ Determining what is and is not suicide is itself difficult. For example, the DoD may not count overdoses, single-vehicle wrecks, weapon misfires, and the like as completed suicides; reconstructing a narrative of suicide is prone to error. However, the cited rates for both veterans and active duty components fail to include Reservists and National Guardsmen. While the suicide rate among Reservists is currently proportionate to that of the general population and active component service members, the National Guard's rate has remained significantly higher than the general population. The most recent data from 2018 showed they had a rate of 30.6 per 100,000.³¹ It is not clear why rates for the National Guard would be higher, which is a point worth more investigation.

Even counting all deaths (including hostile and non-hostile incidents) in the Global War on Terror, which total 7,057, there are more than triple the number of post-9/11 veteran suicide deaths. Adding the estimated 5,116 active-duty personnel who died by suicide since the beginning of the War on Terror, the 1,193 National Guard service members, and 1,607 Reserve component service members who died by suicide between 2011 and 2020 to the conservative estimate of 22,261 post-9/11 veteran suicides, the numbers become even more devastating. Totaling a minimum of 30,177, the growing number of suicides among War on Terror service members and veterans illustrates a dire reality of the mental health costs of post-9/11 wars.

What May Be Unique About the Post-9/11 Wars

Active service member suicide rates have grown during the Global War on Terror to surpass any service member suicide rates since before World War II. In the past, active service member suicide rates actually tended to decrease in wartime, except during the Vietnam War. The rising rates over the last two decades of the post-9/11 wars raise several questions. What led to increases in the Vietnam War and the Global War on Terror? What is novel about the War on Terror that may contribute to suicidal behavior?

To briefly put this in a longer historical context, it is worth mentioning, even with today's alarming high rates, military suicide rates are still lower than in much of the pre-World War II era.³² One may speculate the reason for this is the massive growth in understanding, identifying, and treating mental health issues in the last better part of a century. It is likely also a matter of scale, as the military is significantly larger today. In addition,

²⁹ As they note in Under Secretary of Defense for Personnel and Readiness (2019, September 13), p. 8 [nn4,5], “suicidal intent is rarely known,” and “the establishment of ‘intent’ in manner of death determinations can be difficult and often varies.”

³⁰ Smith et al. (2019), p. 6.

³¹ See Under Secretary of Defense for Personnel and Readiness (2019, September 13) as well as other previous Defense Suicide Prevention Office annual reports since 2008.

³² Smith et al. (2019).

improvements in life-saving medical practices, protective equipment, and strategies that limit boots on the ground to prevent physical injury simply keep more service members alive and often unscathed.³³ Such advances in both mental and physical health illustrate why suicide rates may be lower today by comparison to the pre-WWII period. That said, the data available on suicide rates among active duty personnel and veterans throughout U.S. history are spotty and inconsistent with changing definitions of who ought to count in such figures.

Diminishing Approval and Interest

Diminishing approval of the wars, coupled with damaging veteran stereotypes, may contribute to today's rising service member and veteran suicide rates. Unlike the public's celebratory treatment of World War II veterans as heroes, sections of the public have met the return of veterans from Vietnam and the War on Terror with hostility for the former and often disinterest for the latter. Much like the Vietnam War, public approval of combat operations in Iraq has declined over the last 20 years from 71 percent in 2003 to 43 percent in 2018.³⁴ Similarly, over half of American citizens and almost 60 percent of veterans do not think the U.S. has clear strategic objectives in Afghanistan, with even more believing the war has not been a success.³⁵ In an even more recent poll, 60 percent of Americans do not support military action against Iran.³⁶ By comparison, 60 percent of the public approved sending troops to Vietnam in 1965 compared to only 29 percent by 1973.³⁷ The lowering approval of the Global War on Terror (and that of the Vietnam War) may point to one reason suicide rates have continued to climb. Where Vietnam veterans were called "baby killers" and treated with outright hostility, post-9/11 veterans face a public increasingly disinterested and even ignorant of the war. A poll in 2018 found that about 42 percent of American voters were either unaware of the continuing conflicts in the Middle East or were convinced the War on Terror was over.³⁸ Such a realization must make the reality of fighting a war on behalf of an uncaring public difficult.

³³ For example, see MacLeish, K. (2019). *Imagining Military Suicide*. In C. Lutz & A. Mazzarino (Eds.), *War and Health: The Medical Consequences of the Wars in Iraq and Afghanistan* (pp. 190-208). New York, NY: New York University Press.

³⁴ Oliphant, J. B. (2018, March 19). *The Iraq War continues to divide the U.S. public, 15 years after it began*. Pew Research Center. <https://www.pewresearch.org/fact-tank/2018/03/19/iraq-war-continues-to-divide-u-s-public-15-years-after-it-began/>

³⁵ Data comes from surveys of over 1200 U.S. citizens and over 600 current and former military personnel found in Charles Koch Institute. (2018, October 8). *Seventeen Years On, Americans—Including Veterans—Want Out of Afghanistan*. <https://www.charleskochinstitute.org/news/afghanistan-17-anniversary-poll/>

³⁶ Data produced from a survey of over 1000 U.S. citizens found in Charles Koch Institute. (2020, January 23). *New Poll: Americans Want Troops Home from Afghanistan, Iraq; Opposed to More Military Engagement*. <https://www.charleskochinstitute.org/news/new-poll-americans-want-troops-home-from-afghanistan-iraq-opposed-to-more-military-engagement/>

³⁷ Newport, F., & Carroll, J. (2005, August 24). *Iraq Versus Vietnam: A Comparison of Public Opinion - Gallup Reviews Public Opinion during the Vietnam War and the Current War in Iraq*. Gallup. <https://news.gallup.com/poll/18097/iraq-versus-vietnam-comparison-public-opinion.aspx>

³⁸ Data comes from a Rasmussen Reports survey of 1,000 likely voters conducted between July 25-26, 2018 found in Rasmussen Reports. (2018, July 30). *Do Voters Know We're Still at War With Afghanistan?*

The apparent disinterest among the public can fuel a feeling of purposelessness and a lack of belonging. The loss of stature and purpose color the experiences of many veterans returning home. Their disapproval of the war may itself enhance the guilt and shame that accompany acts of perpetration and precipitate moral injuries and other traumas. They must navigate between stereotypes endlessly propagated by the public that “link the violence of war military discipline to troops’ presumed heroism and virtue, their exploitation and manipulation by the military, or their menacing deviance, pathology, and propensity for violence.”³⁹ Just as one civilian may profusely and earnestly say, “Thank you for your service!” another may fear the veteran for perceived brokenness or craziness, even while some may not care either way. Feeling both set apart from society and a burden to it can trigger the onset of suicidal behaviors.⁴⁰ If there is something novel to the Global War on Terror, it may be the diminishing approval and ignorance of the public coupled with persistent veteran stereotypes, which further alienate them from civilian society.

Medical Advances and the Protracted Length of the War

Another possible cause for the increased post-9/11 suicide rate is the sheer length of the war in tandem with advances in technology and medicine that see service members redeployed after severe injuries. A byproduct of the protracted war and the contemporary advancements in equipment, technology, and medicine is more service members survive and live to fight another day, tasked with returning to combat after surviving.⁴¹ Post-9/11 service members survive serious wounds 87 percent of the time, 18 percent higher than Vietnam or even the Gulf War.⁴² At least a third of previously injured service members redeploy at least once, if not more.⁴³

Modern medical advances have the benefit of allowing service members to survive physical traumas; however, their quality of life following severe physical trauma can put them at a greater risk of suicidal behaviors. For instance, veterans with severe, prolonged pain stemming from physical trauma – sometimes referred to as pain syndrome – are 33 percent more likely to attempt suicide than those with no, mild, or moderate pain. Pain increases suicide risk “due to catastrophic thinking related to the inevitability or

https://www.rasmussenreports.com/public_content/politics/current_events/afghanistan/do_voters_know_we_re_still_at_war_with_afghanistan

³⁹ MacLeish, K. (2019), p. 202.

⁴⁰ Joiner, T. E., & Silva, C. (2012). Why People Die by Suicide: Further Development and Tests of the Interpersonal-Psychological Theory of Suicidal Behavior. In P. R. Shaver & M. Mikulincer (Eds.), *Meaning, Mortality, and Choice: The Social Psychology of Existential Concerns* (pp. 325-336). Washington, DC: American Psychological Association, p.326.

⁴¹ The positive of surviving physical trauma should be clear; however, the point is multiple redeployments after such injuries has been linked with increased suicidal behavior.

⁴² Waszak, D. L., & Holmes, A. M. (2017). The Unique Health Needs of Post-9/11 U.S. Veterans. *Workplace Health & Safety*, 65(9), 430-444.

⁴³ Ibid.

uncontrollability of pain.”⁴⁴ In addition, we know from previous wars that sustaining physical wounds in combat that require hospitalization, particularly more than once, increased the risk of suicide by a range of 22 to even 58 percent depending on the number of hospitalizations.⁴⁵

The Rise of Improvised Explosive Devices and Traumatic Brain Injuries

Furthermore, with increased exposure to the novel use of improvised explosive devices (IEDs) in the War on Terror, there has been an attendant rise in traumatic brain injuries, stress, and burnout. IEDs accounted for over half of casualties early in the war, and their frequency numbered in the thousands per month.⁴⁶ Their persistent use contributes to a constant state of fear and vulnerability, increasing “operational stress burden” and has been linked to increases in active duty suicidal behaviors by 26 percent among military personnel for every additional 1,000 IEDs encountered per month.⁴⁷ The association affects early career service members more, suggesting the fear of threat places a persistent burden and stress on combatants and may lead to psychosocial stress and burnout.

In addition to the threat of IEDs, service members have also faced increases in the number of traumatic brain injuries (TBIs) and mild traumatic brain injuries (mTBIs) yet have been persistently redeployed even after surviving one or more of them, which ought to raise serious red flags. Caused by blast injuries from IEDs, collisions and rollovers, or any situation causing blunt trauma to a service member’s head, TBIs are the “signature injury” of the Iraq and Afghanistan conflicts, affecting between 8 and 20 percent of military personnel.⁴⁸ In a study of over 150 military personnel serving in Iraq in 2009, the average number of TBIs per person was over two injuries with the highest reported being 18, and the researchers found TBIs increased a service member’s risk of suicide with a higher frequency of TBIs correlating with higher risk.⁴⁹ More recent scholarship has increasingly studied polytrauma among service members and veterans. As they continue to survive and continue to redeploy, new veterans return home with chronic pain, TBIs, and PTSD, or what clinicians refer to as the “clinical triad.”⁵⁰ Not surprisingly, these studies also found a

⁴⁴ Ilgen, M. A., Zivin, K., Austin, K. L., Bohnert, A. S., Czym, E. K., Valenstein, M., & Kilbourne, A. M. (2010). Severe pain predicts greater likelihood of subsequent suicide. *Suicide and Life-Threatening Behavior*, 40(6), 597-608, p. 604.

⁴⁵ Bullman, T. A., & Kang, H. K. (1996). The risk of suicide among WOUNDED Vietnam veterans. *American Journal of Public Health*, 86(5), 662-667.

⁴⁶ Wilson, C. (2007, August 28). *Improvised Explosive Devices (IEDs) in Iraq and Afghanistan: Effects and Countermeasures* (Rep. No. RS22330). <https://fas.org/sgp/crs/weapons/RS22330.pdf>

⁴⁷ Ursano, R. J., Kessler, R. C., Naifeh, J. A., Mash, H. H., Fullerton, C. S., Bliese, P. D., . . . Stein, M. B. (2017). Frequency of Improvised Explosive Devices and Suicide Attempts in the U.S. Army. *Military Medicine*, 182(3-4), 1697-1704.

⁴⁸ Bryan, C. J., & Clemans, T. A. (2013).

⁴⁹ Ibid.

⁵⁰ See both Finley, E. P., Bollinger, M., Noël, P. H., Amuan, M. E., Copeland, L. A., Pugh, J. A., . . . Pugh, M. J. (2015). A National Cohort Study of the Association Between the Polytrauma Clinical Triad and Suicide-Related Behavior Among US Veterans Who Served in Iraq and Afghanistan. *American Journal of Public Health*, 105(2), 380-387 and Blakey, S. M., Wagner, H. R., Naylor, J., Brancu, M., Lane, I., Sallee, M., . . . Elbogen, E. B.

strong association with increases in suicidal ideation and behaviors and a propensity towards violence. A tragic consequence of having an all-volunteer force in a smaller military with extended deployments and more survivable trauma is, if servicemembers redeploy — once or often many times — they then must face the threat of suicide. Once they finally rest after a military career, they may find themselves fighting a new inner war at home.

Combat Exposure and Other Possible Factors

There is no consensus on whether the frequency, length, or exposure to combat in deployments increases the chances of suicide. However, these do appear to be associated with an increased risk of PTSD, which has a significant association with suicidal behavior both in the general population and among military personnel.⁵¹ In particular, a study of Ohio National Guardsmen found those with PTSD were 5.4 times more likely to commit suicide. Worse, if they also had at least two other mental health conditions like anxiety, depression, or alcohol abuse, they were 7.5 times more likely.

However, there is not a significant association between combat deployment and suicide alone.⁵² Although combat deployment alone may not be to blame for higher rates of suicide, factors like other traumas and experiences likely are.⁵³ Nondeployed troops have an even higher risk of suicide, and it is not clear why. Some have suggested the possibility that physicians appropriately screened out those with mental health conditions before deployment or that access to mental health resources is more readily available to deployed components than non-deployed ones.⁵⁴ Others have suggested military life's intense operational tempo spreads well beyond the battlefield, and violence can affect service members even if they never deploy.⁵⁵

Research shows a disproportionate number of service members who die by suicide are young (in their twenties), white, non-Hispanic, males in the Army or Marine Corps.⁵⁶

(2018). Chronic Pain, TBI, and PTSD in Military Veterans: A Link to Suicidal Ideation and Violent Impulses? *The Journal of Pain*, 19(7), 797-806.

⁵¹ See Stein et al. (2010) for general population. See for example, Kang, H. K., Bullman, T. A., Smolenski, D. J., Skopp, N. A., Gahm, G. A., & Reger, M. A. (2015). Suicide Risk among 1.3 Million Veterans Who Were on Active Duty during the Iraq and Afghanistan Wars. *Annals of Epidemiology*, 25, 96-100; Macgregor, A. J., Han, P. P., Dougherty, A. L., & Galarneau, M. R. (2012). Effect of Dwell Time on the Mental Health of US Military Personnel With Multiple Combat Tours. *American Journal of Public Health*, 102(S1), S55-S59; Calabrese, J. R., Prescott, M., Tamburrino, M., Liberzon, I., Slembariski, R., Goldmann, E., . . . Galea, S. (2011). PTSD Comorbidity and Suicidal Ideation Associated with PTSD Within the Ohio Army National Guard. *The Journal of Clinical Psychiatry*, 72(08), 1072-1078 for military personnel.

⁵² Reger, M. A., Smolenski, D. J., Skopp, N. A., Metzger-Abamukang, M. J., Kang, H. K., Bullman, T. A., Gahm, G. A. (2015). Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation From the US Military. *JAMA Psychiatry*, 72(6), 561-569.

⁵³ Ibid.

⁵⁴ Kang et al. (2015).

⁵⁵ See MacLeish. (2019) and Finley, E. P. (2012). *Fields of combat: Understanding PTSD among veterans of Iraq and Afghanistan*. Ithaca, NY: Cornell University Press.

⁵⁶ O'Donnell (2012a) and Kang et al. (2015),

Rates were also 24 percent higher for those who were divorced or separated from their romantic partners or experiencing financial hardship. The DoD is quick to point out these trends follow those of the general population and should not imply having these characteristics alone makes one more susceptible.⁵⁷ However, it is significant that they match that of the general population, meaning “the typical military suicide looks a lot like a typical service member, but also ... a lot like a typical American civilian suicide.”⁵⁸ Rising suicide rates among the general population are a significant factor in determining why current rates increase. Further, there may be some significance to younger service members having a higher likelihood of suicide. Some speculate the prolonged wars in Afghanistan and Iraq enlist more young people who may have a “higher level of risk-taking behaviors,” like binge-drinking.⁵⁹ Heavy or binge-drinking, along with other alcohol-related issues, constitute a significant covariate with the risk of suicide.⁶⁰ Also, a 2012 study found post-deployment troops had significantly higher levels of perception of one’s invincibility and survival skills. The result was a direct increase in risky behaviors like binge-drinking and reckless driving.⁶¹ In addition to the covariate of binge-drinking, reckless driving has been linked with increased risk of suicide, particularly among service members with PTSD or an mTBI/TBI.⁶² While demographic factors and risk-seeking behaviors may appear to correlate with higher suicide rates, they do not account for increasing rates alone. Still, they may be a part of the puzzle of rising military suicide rates.

General Causes of Suicide among U.S. Military Veterans and Service Members

In the process of exploring the bigger picture of veteran and active duty suicide, we must also consider factors likely true of all modern U.S. wars, not solely the novel ones above.

Traumatic Experience and PTSD

One clear contributor to the tendency towards suicide affecting many service members across every branch (in both combat and support roles) is exposure to traumatic events. A 2012 study on exposure to traumatic events among U.S. allies in Afghanistan found a little less than half of all deployed service members experienced at least one

⁵⁷ Under Secretary of Defense for Personnel and Readiness (2019, September 13).

⁵⁸ MacLeish. (2019), p. 197.

⁵⁹ Kang et. al. (2015), p.99.

⁶⁰ See LeardMann A., Powell, T. M., Smith, T. C., Bell, M. R., Smith, B., Boyko, E. J., . . . Hoge, C. W. (2013). Risk Factors Associated With Suicide in Current and Former US Military Personnel. *JAMA*, 310(5), 496-506, which suggests between 18 and 11% of suicides could be prevented by eliminating alcohol abuse in the military.

⁶¹ Kelley, A. M., Athy, J. R., Cho, T. H., Erickson, B., King, M., & Cruz, P. (2012). Risk propensity and health risk behaviors in U.S. army soldiers with and without psychological disturbances across the deployment cycle. *Journal of Psychiatric Research*, 46(5), 582-589.

⁶² The reckless driving was associated with stated thoughts of “intentionally driving a vehicle into another object.” See James, L. M., Strom, T. Q., & Leskela, J. (2014). Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI. *Military Medicine*, 179(4), 357-363.

traumatic event, and just under 13 percent experienced more than three.⁶³ In a study of over 100,000 surveyed households worldwide by the World Health Organization, psychiatrists determined exposure to traumatic events had a strong association with suicidal behavior, with exposure to multiple events increasing this association.⁶⁴ That same study determined while traumatic events were associated with the development of post-traumatic stress disorder (PTSD), the data did not suggest PTSD accounted for all suicidal behavior. Besides PTSD, which is a physiological response to traumatic events, one could have other manifestations of trauma contributing to suicidal ideation and behavior. This section will explore the rates and effects of different manifestations of trauma, including PTSD, moral injury (MI), and military sexual trauma (MST), to pinpoint the associations between different kinds of trauma and suicidal behavior.

Service members that have PTSD likely perpetrated, witnessed, or experienced a horror of war, causing an overwhelming sense of fear, which "triggers an alarm system set deep in the amygdala."⁶⁵ The individual is then incapable of turning off the biological fight or flight response to danger; that is, PTSD is an actual physiological (and psychological) response to traumatic events. When false alarms, like loud noises – even the sounds of children – trigger that reaction, there is "perceived threat and automatic response," which we can understand as "fear-circuitry dysregulation."⁶⁶ PTSD is a "technical name for a complex of symptoms that arise in the wake of trauma."⁶⁷ It has symptoms that fall within three categories: "re-experiencing" (e.g., nightmares), "avoidance" (e.g., avoiding talking about the event), and "arousal" (e.g., jumpiness or difficulty sleeping).⁶⁸ The symptoms last for at least one month and result in distress and impairment in social functioning. In a given year, between about 11 and 20 percent of veterans are diagnosed with PTSD, with 27 percent of all War on Terror veterans who seek V.A. healthcare services having a PTSD diagnosis.⁶⁹ The symptoms tend to only be diagnosable as PTSD six months after a traumatic event, although some symptoms may occur immediately. As mentioned, PTSD is associated with suicidal behavior on its own, let alone when combined with other traumas.

⁶³ Wittchen, H., Schönfeld, S., Kirschbaum, C., Thurau, C., Trautmann, S., Steudte, S., . . . Zimmermann, P. (2012). Traumatic Experiences and Posttraumatic Stress Disorder in Soldiers Following Deployment Abroad. *Deutsches Aerzteblatt International*, 109(35-36), 559-568.

⁶⁴ Stein, D. J., Chiu, W. T., Hwang, I., Kessler, R. C., Sampson, N., Alonso, J., . . . Nock, M. K. (2010). Cross-National Analysis of the Associations between Traumatic Events and Suicidal Behavior: Findings from the WHO World Mental Health Surveys. *PLoS ONE*, 5(5).

⁶⁵ Wood, D. B. (2016). *What Have We Done: The Moral Injury of Our Longest Wars*. New York, NY: Little, Brown and Company, p. 15.

⁶⁶ *Ibid.*, p. 16.

⁶⁷ Finley, E. P. (2012), p. 5.

⁶⁸ Bagalman, E. (2011, July 18). *Suicide, PTSD, and Substance Use Among OEF/OIF Veterans Using VA Health Care: Facts and Figures* (Rep. No. R41921). p. 3.

⁶⁹ *Ibid.*; Also, see National Center for PTSD. *How Common Is PTSD in Veterans?* (2018). U.S. Department of Veterans Affairs. https://www.ptsd.va.gov/understand/common/common_veterans.asp

Moral Injury

Service members may also deal with the aftermath of trauma without developing PTSD. Rather than a physiological response, one may instead develop a wound of the soul, or one's core moral self. Moral injury is the term psychiatrists, chaplains, and scholars use to describe "experiences of serious inner conflict arising from what one takes to be grievous moral transgressions that can overwhelm one's sense of goodness and humanity."⁷⁰ In other words, moral injury is the result of trauma that shakes the foundations of one's sense of moral goodness, right and wrong. Indeed, although service members come home with other psychological and physical injuries, moral injury is a "trauma as real as a flesh wound."⁷¹ Although the concept has only become prominent in the last 15 years or so and is yet to have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) entry for psychiatrists to use when making an official diagnosis, it has risen to the forefront of psychiatric research.

A service member suffering from moral injury likely displays "anxiety, depression, sleeplessness, anger," which a person with PTSD may also present. However, as journalist and author David Wood explains, "sorrow, remorse, grief, shame, bitterness, and moral confusion – *What is right?* – signal moral injury, while flashbacks, loss of memory, fear, and a startle complex seem to characterize PTSD."⁷² To those symptoms, we can also add suicidal ideation, rage, and impaired "basic social and cognitive capacities ... required for democratic participation."⁷³ It may be possible for an individual to have both moral injury and PTSD, but they are not the same, and one does not necessarily indicate the other. Moral injury is at its core the loss of one's sense of self due to a transgression against one's most deeply held beliefs and moral values.

There remains no agreed-upon definition of moral injury. However, psychiatrists generally understand moral injury in terms of perpetration or betrayal. Perpetration may include performing, "failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs."⁷⁴ By contrast, betrayal may include transgressions against one's set of moral beliefs that result in shame, grief, meaninglessness, and

⁷⁰ Sherman, N. (2015). *Afterwar Healing the Moral Injuries of Our Soldiers*. New York, NY: Oxford University Press, p. 8.

⁷¹ Wood. (2016), p. 8.

⁷² *Ibid.*, p. 17.

⁷³ Shay, J. (2002). *Odysseus in America: Combat Trauma and the Trials of Homecoming*. New York, NY: Scribner, p. 177.

⁷⁴ Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy. *Clinical Psychology Review*, 29(8), p. 700.

remorse.”⁷⁵ Research has associated both types of moral injury (betrayal and perpetration) with the development of PTSD.⁷⁶

Moreover, psychiatrists’ different definitions of moral injury describe a similar breakdown in significant relationships. On the one hand, perpetration may represent a betrayal of oneself, violating one’s expected moral self-narrative (i.e., “I am a good person”). By contrast, one may feel betrayed by a superior officer or by the military organization itself. In these cases, moral injury may result from a feeling that a significant relationship rooted in authority, but which has an assumption of moral goodness, has betrayed the service member.⁷⁷ In either case, this felt betrayal may result in moral injury, which appears to have a strong association with self-injurious thoughts and behaviors. Perceived transgressions against one’s sense of morality had the strongest association with ongoing suicidal ideation among 151 active duty military personnel compared with transgressions of others or betrayal by others.⁷⁸

The actual rates of moral injury are difficult to determine because there are not agreed-upon measurements, nor (as mentioned) is there an official DSM-5 category specifying its parameters. That said, a study of mental health during Operation Iraqi Freedom determined 27 percent of service members in the theater of war faced “ethical situations during deployment in which they did not know how to respond.”⁷⁹ While we know between 11 and 20 percent of veterans are diagnosed with PTSD each year, research shows a strong correlation between moral injury symptoms and a PTSD diagnosis, with 90 percent of veterans with PTSD having at least one significant symptom of moral injury.⁸⁰ Additionally, the military medical community has “acknowledged an ‘epidemic’ of psychological trauma, with a half-million troops diagnosed with symptoms common to PTSD and moral injury.”⁸¹ While an exact number of those with moral injury may be difficult to determine, it is a significant part of many service members and veterans’ military experience. Research must continue to highlight it as a potential cause of the increasing rates of military suicides.

⁷⁵ Brock, R. N., & Lettini, G. (2013). *Soul Repair: Recovering from Moral Injury after War*. Boston, MA: Beacon Press, p. xiv.

⁷⁶ Jordan, A. H., Eisen, E., Bolton, E., Nash, W. P., & Litz, B. T. (2017). Distinguishing War-Related PTSD Resulting from Perpetration- and Betrayal-based Morally Injurious Events. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(6), 627-634.

⁷⁷ Moral injury may have yet a third dimension, a perceived betrayal and breakdown in the significant relationship one has with the divine. This may account for the common spiritual struggle that often accompanies moral injury but may be more specific in nature than the concept of spiritual injury by itself.

⁷⁸ Bryan, A. O., Bryan, C. J., Morrow, C. E., Etienne, N., & Ray-Sannerud, B. (2014). Moral Injury, Suicidal Ideation, and Suicide Attempts in a Military Sample. *Traumatology*, 20(3), 154-160.

⁷⁹ Quoted from Litz et al. (2009), p. 696, referencing Mental Health Advisory Team (MHAT-IV). (Nov. 17, 2006). Operation Iraqi Freedom 05-07.

⁸⁰ Koenig, H. G., Youssef, N. A., & Pearce, M. (2019). Assessment of Moral Injury in Veterans and Active Duty Military Personnel with PTSD: A Review. *Frontiers in Psychiatry*, 10(443), p. 2.

⁸¹ Wood. (2016), p. 80.

Military Sexual Trauma

Some readers may imagine the traumas that contribute to suicidal behaviors most commonly involve combat experiences. However, as mentioned, some research has shown that combat exposure and lengthy deployments are not strongly associated with the onset of suicidal behaviors.⁸² On the contrary, research suggests non-deployed service members were more likely to commit suicide than deployed service members, particularly in the first three years after leaving the service. There may be many reasons for this, and some question the conclusions of these studies, arguing combat has an association with suicidal ideation.⁸³ However, trauma may commonly occur outside of combat. As one veteran explained, "I'm not a combat veteran, but I didn't have to go to combat to go through something incredibly horrifying." The veteran in question experienced military sexual trauma far from the theater of war and must continue to deal with adverse mental health symptoms after her attack, representing one significant form of trauma one may experience without ever deploying.

The repeated threat or experience of sexual violence, harassment, or assault within the military context constitutes Military Sexual Trauma (MST), which affects over 23 percent of women in the military. This is an underestimate, as a significant portion of MST likely goes unreported. In addition to sexual assault, sexual harassment also affects both women (55 percent of women in the military) and men (38 percent of men in the military). Incidents of MST may include "rape, forcible sodomy, indecent assault, and any attempts of these violations [as well as] sexual coercion, unwanted sexual attention, or threatening attempts to initiate a sexual relationship."⁸⁴ There is also a significant link between MST and PTSD. Research has revealed 71 percent of all women veterans seeking treatment for PTSD had experienced MST. Women veterans who had experienced MST were five times more likely to develop PTSD than their peers who had not experienced it.⁸⁵ Despite this link to PTSD, MST may not always result in the disorder. However, it may lead to other mental health disorders strongly associated with sexual trauma among female veterans like "major depressive disorder, anxiety, and substance abuse."⁸⁶

Psychiatrists and other scholars often separate MST from other forms of trauma like combat trauma, morally injurious events, and the like, even while it may, like other forms of

⁸² For example, Leard Mann et al. (2013), which followed over 145,000 active duty personnel from 2001 to 2007.

⁸³ See Kang et al. (2015). and Kang, H. K., & Bullman, T. A. (2008). Risk of Suicide Among US Veterans After Returning from the Iraq or Afghanistan War Zones. *JAMA*, 300(6), 652-653.

⁸⁴ Conard, P. L., Young, C., Hogan, L., & Armstrong, M. L. (2014). Encountering Women Veterans with Military Sexual Trauma. *Perspectives in Psychiatric Care*, 50(4), p. 282.

⁸⁵ See both Murdoch, M., Polusny, M. A., Hodges, J., & O'Brien, N. (2004). Prevalence of In-Service and Post-Service Sexual Assault among Combat and Noncombat Veterans Applying for Department of Veterans Affairs Posttraumatic Stress Disorder Disability Benefits. *Military Medicine*, 169(5), 392-395. and Suris, A., Lind, L., Kashner, T. M., & Borman, P. D. (2007). Mental Health, Quality of Life, and Health Functioning in Women Veterans. *Journal of Interpersonal Violence*, 22(2), 179-197.

⁸⁶ Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More Than Military Sexual Trauma: Interpersonal Violence, PTSD, and Mental Health in Women Veterans. *Research in Nursing & Health*, 34(6), p. 458.

trauma, result in PTSD or moral injury, mainly because it is such an act of betrayal. The feeling of betrayal is part of what makes MST distinctive from sexual trauma in the civilian sector. Health scientist Patricia Conrad explains, “MST is unique in that it usually occurs in the workplace setting and often by someone known,” and the victim likely must continue to work with their attacker, which may lead to feelings of betrayal, shame, and hopelessness.⁸⁷ A service member usually cannot just leave the service whenever they choose. Moreover, 73 percent of those who report MST are met with retaliation and organizational minimization, leading to enhanced trauma for those reporting and a pattern of underreporting for others.⁸⁸ Service members who suffer MST feel an overwhelming sense of captivity while simultaneously losing their sense of identity and worth. Like PTSD and moral injury, MST has a close association with suicidal behaviors and ideation, particularly among men. One study found approximately 75 percent of MST survivors reported experiencing post-MST suicidal ideation overall. Further, about 40 percent reported attempting suicide following MST.⁸⁹

Other Mental Health Concerns

Many other mental health factors may have a causal link to suicidal behaviors. A 2012 surveillance report of all active duty U.S. Armed Forces personnel found annual counts and rates of mental disorders among active duty service members increased by about 65 percent from 2000 to 2011.⁹⁰ Suicide rates themselves nearly doubled in that time from 10.1 to 19.7, and the attendant increase in mental health problems among active component military personnel should raise concern.⁹¹ Interestingly, PTSD accounted for only 5.7 percent of new diagnoses during this time. Most new mental health problems were adjustment disorders (26.3 percent), depressive disorders (16.9 percent), alcohol abuse and dependence (13 percent), and anxiety disorders (10.5 percent). Each of these mental health problems has an association with suicidal behavior. For example, those with adjustment disorders, diagnosed following an individual’s inability to cope with or recover from a significant stressor (like the death of a loved one), are 12 times more likely to take their own life than those without them.⁹² Additionally, depression highly correlates with

⁸⁷ Conrad. (2014). p. 282.

⁸⁸ See Britch. (2020) and Bergman, M. E., Langhout, R. D., Palmieri, P. A., Cortina, L. M., & Fitzgerald, L. F. (2002). The (Un)reasonableness of Reporting: Antecedents and Consequences of Reporting Sexual Harassment. *Journal of Applied Psychology*, 87(2), 230-242.

⁸⁹ See Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R. V., & McCarthy, J. F. (2016). Military Sexual Trauma and Suicide Mortality. *American Journal of Preventive Medicine*, 50(6), 684-691; Bryan, C. J., Bryan, A. O., & Clemans, T. A. (2015). The Association of Military and Premilitary Sexual Trauma with Risk for Suicide Ideation, Plans, and Attempts. *Psychiatry Research*, 227, 246-252; and Monteith, L. L., Holliday, R., Schneider, A. L., Forster, J. E., & Bahraini, N. H. (2019). Identifying factors associated with suicidal ideation and suicide attempts following military sexual trauma. *Journal of Affective Disorders*, 252, 300-309.

⁹⁰ O'Donnell, F. L. (Ed.). (2012b). Mental Disorders and Mental Health Problems, Active Component, U.S. Armed Forces, 2000-2011. *Medical Surveillance Monthly Report*, 19(6), 11-17.

⁹¹ See O'Donnell. (2012a) and Kang et al. (2015).

⁹² Gradus, J. L., Qin, P., Lincoln, A. K., Miller, M., Lawler, E., & Lash, T. L. (2010). The association between adjustment disorder diagnosed at psychiatric treatment facilities and completed suicide. *Clinical Epidemiology*, 9(2), 23-28.

suicidal ideation, attempts, and completion; around 15 to 20 percent of those with depression die by suicide.⁹³ Alcohol abuse and dependency are covariates of suicidal behaviors, primarily because of alcohol's depressogenic effects, and any baseline of an anxiety disorder was strongly associated with suicide attempts and ideation.⁹⁴ That is to say, an increase in the number of service members diagnosed with these additional mental health problems must explain a significant portion of the increase in suicide among service members over the last two decades.

Finally, research has found childhood abuse and pre-service sexual trauma were both associated with higher risks of suicide. Nearly three-quarters of new soldiers in the Army report previous traumatic experiences upon joining the service, and a fifth of those experiences is child abuse.⁹⁵ Research strongly links childhood abuse to suicidal behaviors, even when accounting for new traumas service members may experience in the military.⁹⁶ Furthermore, while MST has a strong association with suicidal behaviors on its own, as shown above, pre-military sexual assaults had a stronger association among women in the military and suicidal behaviors, made even worse if they then experienced MST as well.⁹⁷ These studies highlight the importance of considering prior traumatic experiences in the stories of those who serve, particularly if this may have a bearing on the growth in suicide rates during the last 20 years.

Military Culture

In addition to the sources of trauma service members may experience in or bring to the military, the U.S. Armed Forces has an influential hierarchical and hegemonic masculine culture that may significantly contribute to avoidance of help-seeking behaviors. In other words, service members may be less likely to reflect on their experiences or to seek help for their trauma for fear of looking weak or unmanly in the eyes of their subordinates, peers, and commanding officers.

Through intense training and reinforcement of this culture, the military habituates traits within service members that ultimately aim at strategic ends above their individual

⁹³ See Ursano, R. J., Mash, H. B., Kessler, R. C., Naifeh, J. A., Fullerton, C. S., Aliaga, P. A., . . . Stein, M. B. (2020). Factors Associated with Suicide Ideation in US Army Soldiers During Deployment in Afghanistan. *JAMA Network Open*, 3(1), 1-15. Also, see Miret, M., Ayuso-Mateos, J. L., Sanchez-Moreno, J., & Vieta, E. (2013). Depressive Disorders and Suicide: Epidemiology, Risk Factors, and Burden. *Neuroscience & Biobehavioral Reviews*, 37(10), 2372-2374.

⁹⁴ Brady, J. (2006). The Association Between Alcohol Misuse and Suicidal Behaviour. *Alcohol and Alcoholism*, 41(5), 473-478; Sareen, J., Cox, B. J., Afifi, T. O., Graaf, R. D., Asmundson, G. J., Have, M. T., & Stein, M. B. (2005). Anxiety Disorders and Risk for Suicidal Ideation and Suicide Attempts: A Population-Based Longitudinal Study of Adults. *Archives of General Psychiatry*, 62(11), 1249-1257.

⁹⁵ Ursano et al. (2020).

⁹⁶ See both Griffith, J. (2014). Prevalence of Childhood Abuse among Army National Soldiers and Its Relationship to Adult Suicidal Behavior. *Military Behavioral Health*, 2(2), 114-122. and Stein, M. B., Campbell-Sills, L, Ursano, R. J., Rosellini, A. J., Colpe, L. J., He, F., . . . Kessler, R. C. (2018). Childhood Maltreatment and Lifetime Suicidal Behaviors Among New Soldiers in the US Army. *The Journal of Clinical Psychiatry*, 79(2), 70-77.

⁹⁷ Bryan, Bryan, and Clemans. (2015).

well-being. To do this, the military “reconfigures civilian practices and ways of speaking to generate functions and meanings . . . that support the institutional aim.”⁹⁸ The military organization takes language and symbols and whole systems of culture, like religion or national pride, and infuses them with new meaning aimed at military superiority. In addition to this recontextualization of cultural beliefs, the military uses “military biopolitics” to “manage and organize [service members’] bodies and minds, heal, preserve, and care for them, make them disciplined tools of the state, empower them to kill, and deliberately expose them to harm.”⁹⁹ In other words, the military simultaneously prepares service members for participation in violence and the rigors of military life with protective resources while also making it easier, even instinctive, for them to cause harm. For example, through resilience training, which helps improve mental fortitude, service members learn to withstand stress. Simultaneously, they undergo training in reflexive firearm shooting, which “suppresses a combatant’s ability to exercise moral discernment before taking action.”¹⁰⁰ The military trains service members to kill effectively and instinctively while also training them to manage the act of killing through mental resilience psychologically.

Military life is exhausting, and the high operational tempo limits time for reflection.¹⁰¹ Further, the dominant masculine identity that pervades the military is one that overwhelmingly favors machismo and toughness. Asking for help during trauma or suicidal ideation, then, is necessarily at odds with military culture; “acknowledging mental illness is likely to be viewed as a sign of weakness and a potential threat to their careers.”¹⁰²

In general, veterans tend to have a stigma against mental health care and tend to match the general public’s negative view of those who seek help as dangerous and worthy of social avoidance.¹⁰³ A retired Marine officer revealed to me he has actively avoided the diagnosis while suspecting he has PTSD. “I guess, to some degree, it was a practical thing for me,” he said. “No matter what, when you go, and you spend a year in a combat zone or wherever, your mind works in a different way, and even if you're in a combat zone, but you're not involved in combat, your mind still works in a different way. And so, anytime you come home, there is a level of adjustment. Again, even if you're not in combat – and I always tell people, people throw PTSD around like it’s water.” He felt PTSD was over-diagnosed and was a matter of “willpower and their own ability to overcome their own issue.” He admitted to intense “anxiety” but feared an official diagnosis might hinder his job opportunities in civilian life. He felt it was better to look resilient and strong than to look

⁹⁸ Waggoner, E. (2014). Taking Religion Seriously in the U.S. Military: The Chaplaincy as a National Strategic Asset. *Journal of the American Academy of Religion*, 82(3), p. 704.

⁹⁹ MacLeish draws on Foucault for this concept in MacLeish. (2019), p. 191.

¹⁰⁰ Brock and Lettini. (2013). p. xvii.

¹⁰¹ See, for instance, Wood. (2016), p. 18, 186.

¹⁰² Mittal, D., Drummond, K. L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma Associated with PTSD: Perceptions of Treatment Seeking Combat Veterans. *Psychiatric Rehabilitation Journal*, 36(2), p. 87.

¹⁰³ Ibid.

like the persistent stereotype of a mentally broken veteran. Like the marine, other veterans share similar concerns. In one study, “*My mental health problem would go on my record*” and “*I would be seen as weak*” were the most highly endorsed reasons for not seeking help among Operation Enduring Freedom and Operation Iraqi Freedom veterans.¹⁰⁴

Among OEF and OIF veterans, fears of being treated differently by their peers, supervisors, families, and communities were also common. Simultaneously, a general distrust of therapy was pervasive, particularly concerning fears over talking with a stranger or feeling the therapist would not be able to relate.¹⁰⁵ As the vestiges of military culture continue to constitute veterans' dispositions in the months following service, they tend not to seek help at the most critical time. Mental health issues increase in the months following deployments, particularly in the months after returning to civilian life, making help-seeking attitudes a crucial part of the puzzle in suicidal behaviors among both service members and veterans.¹⁰⁶

Individual Moral Responsibility

In addition to its emphasis on machismo and resilience, military culture emphasizes individual moral responsibility over organizational moral responsibility, which may contribute to suicide among those who feel responsible for adverse outcomes. Just war theory is the convention of war that determines what is just cause for war and just action in war. Historically, it places the blame for unjust actions on individual service members' shoulders, even while the justice of going to war remains a question for military and government leaders.¹⁰⁷ The “standard answer” to questions of moral responsibility consistently lays the blame on individual service members “understood to be autonomous moral agents” and “solely responsible for their behavior in war.”¹⁰⁸ Military culture demands obedience, effectively stripping away moral agency. Service members must endure constant yelling, shoot at targets in the shape of human beings without thinking, and obey orders without hesitation or doubt. They must learn to kill, and they must swear an oath upon enlistment that they will “obey the orders of the President of the United States and the order of the officers appointed over [them] according to regulations and the

¹⁰⁴ Porcari, C., Koch, E. I., Rauch, S. A., Hoodin, F., Ellison, G., & Mcsweeney, L. (2017). Predictors of Help-Seeking Intentions in Operation Enduring Freedom and Operation Iraqi Freedom Veterans and Service Members. *Military Medicine*, 182(5), p.1645.

¹⁰⁵ Cornish, M. A., Thys, A., Vogel, D. L., & Wade, N. G. (2014). Post-deployment difficulties and help seeking barriers among military veterans: Insights and intervention strategies. *Professional Psychology: Research and Practice*, 45(6), 405-409.

¹⁰⁶ Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of Mental Health Problems and Functional Impairment Among Active Component and National Guard Soldiers 3 and 12 Months Following Combat in Iraq. *Archives of General Psychiatry*, 67(6), 614.

¹⁰⁷ Michael Walzer explains, “The atrocities that he commits are his own; the war is not” in Walzer, M. (2006). *Just and Unjust Wars: A Moral Argument with Historical Illustrations* (4th ed.). New York, NY: Basic Books, p. 39.

¹⁰⁸ Crawford, N. (2013). *Accountability for Killing Moral Responsibility for Collateral Damage in America's Post-9/11 Wars*. New York, NY: Oxford University Press, p. 225.

Uniform Code of Military Justice.”¹⁰⁹ They must swear obedience, yet service members are held responsible for all of their actions.

Military law even codifies this emphasis on individual moral responsibility. According to the Operational Law Handbook, “the ‘I just followed orders’ defense usually fails. By training and common sense, Soldiers must recognize unlawful orders and act appropriately.”¹¹⁰

Nevertheless, military training and culture limit individual service members’ agency. Political scientist Neta Crawford argues service members’ “individual agency is constrained by military training, the rules of engagement, and the deference to command authority that is required of soldiers” along with the “fear and fatigue that characterize war.”¹¹¹ The constant influence of military culture, along with the duress of military experience, limits service members’ ability to act differently in many cases, so when decisions or actions lead to an immoral consequence, all of that moral blame lands squarely on the shoulders of individual service members. Peers, commanders, and even chaplains may laud them for their actions, yet if moral questions arise within the one who acted, it is the individual service member who feels the blame. Military law codifies individual blameworthiness, yet service members do not readily have an outlet for seeking help for the inevitable dissonance they experience because military culture looks poorly on seeking help.

Service members have access to Resilience Training and Spiritual Fitness programs that target service members’ physical, mental, emotional, and spiritual well-being to strengthen military readiness and reduce mental health issues. The programs are useful in reducing anxiety and stress, and they have been effective in improving coping strategies and reducing self-blame.¹¹² However, these programs also reinforce resiliency and spiritual fortitude on an individual level, with few programs emphasizing community resilience or responsibility.¹¹³ The language embedded in the resiliency programs puts moral responsibility on individual service members. Army Resilience training, for example, emphasizes “personal readiness” and “internal motivation.”¹¹⁴ While Resilience Training and Spiritual Fitness have been proven efficacious in improving coping mechanisms among service members, it further exemplifies the embedded framework of individual moral

¹⁰⁹ Enlistment oath: who may administer, 10 USC § 502.

¹¹⁰ Kouba, D. (Ed.). (2017). *Operational Law Handbook* (17th ed.). Charlottesville, VA: International and Operational Law Department, The Judge Advocate General’s Legal Center and School, p. 39.

¹¹¹ Crawford. (2013), p.226.

¹¹² Rice, V., & Liu, B. (2016). Personal Resilience and Coping Part II: Identifying Resilience and Coping among U.S. Military Service Members and Veterans with Implications for Work. *Work*, 54(2), 335-350.

¹¹³ Yeung, D., & Martin, M. T. (2013). *Spiritual Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-being*. Washington, DC: Rand Corporation.

¹¹⁴ Army Resilience Directorate. (2020). Army Ready and Resilient. <https://www.armyresilience.army.mil/ard/R2/FAQ.html>

responsibility within the military. The experience of self-blame has a strong association with PTSD and suicidal ideation.¹¹⁵

Access to Lethal Means

Access to lethal means, or an accessible method of suicide, is another possible contributor to the persistently high suicide rates among both service members and veterans. Almost half of all veterans own a firearm, with most owning both short- and long-barreled guns.¹¹⁶ It is a gun's ready availability and its high lethality that mark the difference for why a suicidal act proves fatal.¹¹⁷ Simply owning a gun triples the risk of suicide.¹¹⁸

About 65 percent of active military suicides involve a firearm.¹¹⁹ Among veterans, the rate is even higher: almost 70 percent.¹²⁰ By contrast, firearms account for death in 48 percent of suicides in the general population. Service member access to firearms varies, and many weapons remain under lock, key, and guard. Nevertheless, many service members carry weapons on their person or access firearms and ammunition at home. Shockingly, service members with higher access to guns were associated with a fourfold increase in the odds of dying by suicide.¹²¹ Mental health clinicians inside the military and the V.A. can screen service members and veterans to determine high-risk groups. However, it is much more challenging to determine the risk of suicidal behaviors among those who fall into other categories. Almost a quarter of all suicide attempts occur within five minutes of deciding to do so, and 70 percent occur within one hour.¹²²

The Difficulty of Returning to Civilian Life

As service members transition back to civilian life, they face an incredible challenge of reintegration amid the psychosocial stress of losing their role identity as members of the

¹¹⁵ Ross, C. A. (2013). Self-Blame and Suicidal Ideation Among Combat Veterans. *American Journal of Psychotherapy*, 67(4), 309-322.

¹¹⁶ Cleveland, E. C., Azrael, D., Simonetti, J. A., & Miller, M. (2017). Firearm Ownership among American Veterans: Findings from the 2015 National Firearm Survey. *Injury Epidemiology*, 4(33), 1-10.

¹¹⁷ Miller, M., Azrael, D., & Barber, C. (2012). Suicide Mortality in the United States: The Importance of Attending to Method in Understanding Population-Level Disparities in the Burden of Suicide. *Annual Review of Public Health*, 33(1), 393-408.

¹¹⁸ Anglemeyer, A., Horvath, T., & Rutherford, G. (2014). The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members. *Annals of Internal Medicine*, 160(2), 101-110.

¹¹⁹ Pruitt, L. D. (Ed.). (2018). *Department of Defense Suicide Event Report Calendar Year 2017 Annual Report* (Rep. No. F-C3EE053). <https://www.dspo.mil/Portals/113/Documents/2017-DoDSER-Annual-Report.pdf?ver=2019-07-19-110951-577>

¹²⁰ Office of Mental Health and Suicide Prevention. (2019a).

¹²¹ Dempsey, C. L., Benedek, D. M., Zuromski, K. L., Riggs-Donovan, C., Ng, T. H., Nock, M. K., . . . Ursano, R. J. (2019). Association of Firearm Ownership, Use, Accessibility, and Storage Practices With Suicide Risk Among US Army Soldiers. *JAMA Network Open*, 2(6), 1-10.

¹²² Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M., & O'Carroll, P. W. (2002). Characteristics of Impulsive Suicide Attempts and Attempters. *Suicide & Life-Threatening Behavior*, 32(1), 49-59.

U.S. Armed Forces. In a survey of over 700 post-9/11 veterans, about 44 percent reported having difficulty transitioning to civilian life.¹²³

The contributing factors to this difficult transition were numerous. The leading characteristics were whether the veterans experienced a traumatic event, were seriously injured, were married while serving, served in combat, or knew someone killed or injured.¹²⁴ A 2020 study found 40 percent of post-9/11 veterans reported facing many challenges upon transitioning.¹²⁵ This recent study pointed to a loss of identity and purpose, an inability to relate to non-veteran civilians, difficulty in readjusting to social life, mental and physical health concerns, and difficulty navigating V.A. benefits as significant challenges to transition. Of course, these are trends and not the rule. However, they point to how veterans returning to civilian life may bring experiences from the military that make civilian life more difficult. As one Captain in the Green Berets told me, “You don't come home and just reintegrate. It's not like you come back and be, like, ‘Oh, I'm out of the Army. Okay, good, tomorrow I'm going to wake up and be a civilian.’ This is a year or years-long process.”

Not only must new veterans wrestle with the aftereffects of their military experience, but they also must manage the severe culture shock of reintegrating to the slower pace of civilian life and their new role in it. A great deal of culture shock comes from the swift transition from high operational tempo and little sleep to a significant amount of unfilled time. This free time may “reawaken feelings of regret or guilt for having left family for the adventure of war. Grief for lost friends, deferred while in war, can come flooding back.”¹²⁶ Having time to reflect, perhaps for the first time in months or an entire career, may conjure up the soul wounds felt by veterans struggling with moral injury. Civilian life provides a sudden opportunity for reflection. Further, PTSD often does not manifest, nor is it even diagnosable, for several months after trauma, meaning a service member may not realize they have PTSD until they have already returned to civilian life. Time itself makes the transition to civilian life hard because compartmentalization and suppression become less viable.

Even those who never suffer PTSD or moral injury face a loss of identity stemming from a loss of status. Journalist David Wood explains, “for some, leadership in wartime, responsibility for a few soldiers or hundreds, is the high point of a lifetime. Yet that skill, and the authority it conferred, seem to belong back there in the war; here at home the sergeant is just another guy nursing a late-night beer.”¹²⁷ This loss of purpose and importance can precipitate a feeling of a loss of identity. Losing a sense of meaning may make veterans “feel duped or disillusioned and [they may] reject the meaning systems that

¹²³ Morin, R. (2011, December 8). *The Difficult Transition from Military to Civilian Life*. Pew Research Center. <https://www.pewsocialtrends.org/2011/12/08/the-difficult-transition-from-military-to-civilian-life/>

¹²⁴ The study suggests this surprising factor is likely a result of marital strain during deployments.

¹²⁵ Britch. (2020).

¹²⁶ Wood. (2016), p.222.

¹²⁷ Ibid.

made them feel part of something bigger than themselves.”¹²⁸ An Army Command Sergeant Major, for instance, explained to me, “it was very hard for me to transition from being the person who told people what to do and expected exceedingly high standards of execution and mission accomplishment to be involved with failure on a daily basis.” Once in charge of hundreds of soldiers in the Army, now working alongside young people who had never been in the military and did not understand his high-ranking position left him feeling frustrated and distraught. It is difficult for many veterans to return to civilian life with none of the clout their position previously conferred or the sense of purpose their role provided. It meant losing an identity around which they had built their entire world.

The setting in of moral injury and the loss of status may be precipitating factors leading to high rates of suicide. Other challenges often accompany them: unemployment, alcohol and substance abuse, and homelessness are all often implicated in the stories of veterans who die by suicide.

Finding a job may prove difficult for many veterans, particularly those without college degrees, and the “soft skills” they bring with them back to the civilian world may not translate into new jobs.¹²⁹ Veterans may feel they are overqualified for entry-level jobs, while employers may instinctively view them as “dangerous or broken.”¹³⁰ While the veteran unemployment rate was relatively low before the coronavirus pandemic at about 3 percent, it is now at 13 percent for post-9/11 veterans.¹³¹ The unemployment rate is roughly commensurate with the general population, but unemployment does produce a higher relative risk of suicide, which the duration of unemployment worsens.¹³²

Alcohol use disorder affects roughly 7 percent of veterans overall, while substance abuse disorders affect roughly 11 percent of all veterans who use the V.A. health care system.¹³³ Rates of alcohol and substance abuse have continued to rise in the past 20 years. As with active duty personnel, research shows a strong association between alcohol/substance abuse and completed suicides, 30 percent of which were preceded by alcohol and drug abuse.¹³⁴ Prescription drug misuse and alcohol abuse and dependence are

¹²⁸ Brock and Lettini. (2013), p. 49.

¹²⁹ Zogas, A. (2017). US Military Veterans’ Difficult Transitions Back to Civilian Life and the VA’s Response. *Costs of War*, p. 5.

¹³⁰ Ibid.

¹³¹ U.S. Department of Labor. (2019). *Veterans’ Employment and Training Service Newsletter*. <https://www.dol.gov/agencies/vets/newsletter>; Shane, L., III. (2020, May 8). Veteran Unemployment up to Nearly 12 Percent amid Coronavirus Crisis. *Military Times*. <https://www.militarytimes.com/education-transition/2020/05/08/veteran-unemployment-up-to-nearly-12-percent-amid-coronavirus-crisis/>

¹³² Milner, A., Page, A., & LaMontagne, A. D. (2014). Cause and Effect in Studies on Unemployment, Mental Health and Suicide: A Meta-analytic and Conceptual Review. *Psychological Medicine*, 44(5), 909-917.

¹³³ Williams, E. C., Gupta, S., Rubinsky, A. D., Jones-Webb, R., Bensley, K. M., Young, J. P., . . . Harris, A. H. (2016). Racial/Ethnic Differences in the Prevalence of Clinically Recognized Alcohol Use Disorders Among Patients from the U.S. Veterans Health Administration. *Alcoholism: Clinical and Experimental Research*, 40(2), 359-366; Teeters, J., Lancaster, C., Brown, D., & Back, S. (2017). Substance use disorders in military veterans: Prevalence and treatment challenges. *Substance Abuse and Rehabilitation*, 8, 69-77.

¹³⁴ Ibid.

among the strongest predictors of suicide among veterans overall.¹³⁵ On the one hand, this behavior may extend from habits learned in the military itself. A survey of over 16,000 active duty military personnel found about 43 percent of them engaged in binge-drinking, or drinking five or more drinks for men or four or more drinks for women in one sitting.¹³⁶ On the other hand, this behavior may mask the traumas personnel bring back with them. In any case, alcohol and substance abuse remain essential factors and predictors of suicidal behaviors among veterans, and it should remain a substantial piece of the puzzle in proposing causes for rising suicide rates.

Homelessness among veterans is also a potential factor in suicide rates. There are roughly 37,000 identified homeless veterans in the U.S.¹³⁷ While homelessness alone is associated with an increased risk of dying by suicide, it is even worse for veterans. In a recent study of over 36,000 homeless in the U.S., homeless veterans were almost eight times more likely to attempt suicide than their non-homeless veteran counterparts. Non-veteran homeless were only four times more likely. These findings suggest homelessness is itself a suicide risk factor and is worse for veterans.

Veterans and service members who become suicidal likely face many of the associated causes and risk factors listed above. At the heart of these numbers, data, and anecdotes are real stories of people navigating a reality in which they feel out of place and a burden on loved ones and society. Interpersonal-psychological theory claims depression linked to suicide is a product of “low belonging and high burdensomeness.”¹³⁸ In conjunction with access to lethal means, these two factors are likely at the root of the problem. Unemployment, homelessness, addiction, mental and physical health problems, grief, and rage all exacerbate higher levels of burdensomeness while simultaneously disrupting veterans’ ability to participate in places where they feel they meaningfully belong. The alienation and loneliness that come with feeling like no one at home can understand them while also needing to avoid situations that trigger fear responses in the body due to PTSD mark a seemingly impossible situation. How can one feel self-worth or find belonging if the wounds of war persist through the body and deep into the soul?

Conclusion

At least four times as many service members and war veterans of post-9/11 conflicts have died of suicide than ever died in combat. As the war nears the end of its second decade, respective suicide rates for both active duty personnel and veterans have worsened, finding new peaks particularly among 18- to 34-year-olds. Factors like exposure

¹³⁵ Kim, H. M., Smith, E. G., Ganoczy, D., Walters, H., Stano, C. M., Ilgen, M. A., . . . Valenstein, M. (2012). Predictors of Suicide in Patient Charts Among Patients With Depression in the Veterans Health Administration Health System. *The Journal of Clinical Psychiatry*, 73(10), 1269-1275.

¹³⁶ Stahre, M. A., Brewer, R. D., Fonseca, V. P., & Naimi, T. S. (2009). Binge Drinking Among U.S. Active-Duty Military Personnel. *American Journal of Preventive Medicine*, 36(3), 208-217.

¹³⁷ US Department of Veterans Affairs. (2019). *Veterans Experiencing Homelessness: Point-in-Time (PIT) Count - Everyone Counts in the Effort to End Veteran Homelessness*. https://www.va.gov/HOMELESS/pit_count.asp

¹³⁸ Joiner and Silva. (2012), p.326.

to trauma – physical, mental, sexual – stress, burnout, mental health disorders, the onset of PTSD, moral injury, access to lethal means, the difficulty of civilian reintegration, and certain military cultural frames have all played a part. To these, the Global War on Terror has seen a huge increase in IED exposure with an attendant rise in TBIs. Modern medical advances have also allowed service members to survive physical traumas and return to the frontlines for multiple deployments, even though the combination of multiple traumatic exposures, chronic pain, and lasting physical wounds is linked to suicidal behaviors. The sheer length of the war has kept service members in the fight longer, providing more opportunities for traumatic exposure. The U.S. government’s inability to address the suicide crisis is a significant cost of the U.S. post-9/11 wars, and the result is a mental health crisis among our veterans and service members with significant long-term consequences.

The U.S. military and the Department of Veteran Affairs have spent a tremendous amount of money in recent years to combat service member and veteran suicide, yet the funding continues to climb even as suicide rates do not improve. Congress provides \$20 million annually to Department of Defense suicide prevention programs and research, including tens of millions of dollars in research and resilience programs.¹³⁹ Additionally, the V.A. receives billions of dollars every year to combat suicide. For example, the F.Y. 2021 budget for the V.A. has \$10.2 billion set aside for veteran suicide prevention, a 7 percent increase over 2020.¹⁴⁰ Between the DoD and V.A., there is an abundance of resources, programs, and research opportunities that ought to benefit service members and veterans alike. (See Appendix I for more information on the government’s current measures against rising suicide rates)

Existing programs are a step in the right direction, and many of these various organizations and programs do excellent work, but they are expensive and are not adequately addressing the problem. While the V.A. and other actors must persist in caring for veterans, the DoD, VA, and other organizations and actors like IAVA, Wounded Warrior Project, and others who work with veterans and active service members must make preventative measures a priority. Ending the U.S.’s post-9/11 wars would be a good first step, but there are cultural changes that must occur as well. The military needs to promote help-seeking attitudes and frame them positively. Accordingly, medical screenings for PTSD, TBIs, depression, and suicidal ideation must be universal, communicated across all channels, and taken seriously. That polytraumas and repeated TBIs are so commonplace should motivate changes in if and how service members are redeployed. Although limiting the active duty roles of service members with TBIs or persistent mental health issues could precipitate other challenges, the clear link between TBIs, polytraumas, mental health problems, and suicidal ideation should motivate limits on redeployments and significantly expanded dwell time.

¹³⁹ Kamarck, K. N. (2019, October 2). *Military Suicide Prevention and Response* (Rep. No. 7-5700). Congressional Research Service. <https://fas.org/sgp/crs/natsec/IF10876.pdf>

¹⁴⁰ U.S. Department of Veterans Affairs, Office of Public Affairs Media Relations. (2020, February 10). *VA strengthens care and benefits for Veterans with \$243 billion budget request for fiscal year 2021* [Press release]. <https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=5393>

Moreover, the DoD, VA, and other actors should take moral injuries, military sexual trauma, and other traumas outside of the theater of war as seriously as physical wounds and more readily diagnose and respond to them. As service members transition to being veterans, the V.A., too, needs reform, as many have observed. I make more specific recommendations for this in Appendix II.

Unless the U.S. government and U.S. society makes significant changes in the ways we manage the mental health crisis among our service members and veterans, suicide rates will continue to climb. That is a cost of war we cannot accept.

Appendix I: Current Measures Taken by the Government

This appendix gives an overview of what the DoD and the V.A. have done to address service member and veteran suicide. There is an abundance of available resources, programs, and research opportunities supported by government funding and non-profits. It would be almost impossible to list them exhaustively, so what follows highlights some of them, emphasizing programs and policies still actively relevant today.

The military's first line of defense against suicide is Resilience Training, which began in the Army in 2008. Research shows the program has been successful in reducing self-blame and increasing positive coping amid trauma.¹⁴¹ It also appears to reduce deleterious mental health outcomes following trauma some, though not all, of the time.¹⁴² The training targets service members' physical, emotional, social, family, and spiritual fitness and trains service members during active duty and preparation for returning home. Individual branches have individual resilience training programs, assuring the programs meet their specific needs. These programs are also designed to be self-reinforcing and internally motivated in that there are programs, like the Army's Master Resilience Training, that train officers on how to teach resiliency to other soldiers.

Additionally, the military eventually shortened deployments and increased "dwell time" at service members' home bases by 2011.¹⁴³ Deployments vary by branch, but in the Army, which consistently has the highest suicide rate along with the Marine Corps, deployments were 12 months with two years of dwell time. With the heavy demands on fighting multiple wars within the Global War on Terror but acknowledging the impact of deployment on mental health, the Army changed its deployment length to nine months with a two-year dwell time. The average length of deployment for all branches and components is about eight months.¹⁴⁴ Research has shown a lower risk of PTSD with longer dwell times.¹⁴⁵

The military now appears to take access to lethal means more seriously. In 2014, a memorandum from the Under Secretary of Defense gave commanders authorization and guidance to ask about and volunteer a reduction in access to privately-owned firearms.¹⁴⁶

¹⁴¹ Rice and Liu. (2016).

¹⁴² Thompson, S. R., & Dobbins, S. (2017). The Applicability of Resilience Training to the Mitigation of Trauma-Related Mental Illness in Military Personnel. *Journal of the American Psychiatric Nurses Association*, 24(1), 23-34.

¹⁴³ Lineberry and O'Connor. (2012).

¹⁴⁴ Committee on the Assessment of the Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Select Populations; Institute of Medicine. (2013). Characteristics of the Deployed. In *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families* (pp. 31-46). Washington, DC: National Academies Press.

¹⁴⁵ Macgregor, Dougherty, and Galarneau. (2012).

¹⁴⁶ Wright, J. L. (2014). Guidance for Commanders and Health Professionals in the Department of Defense on Reducing Access to Lethal Means Through the Voluntary Storage of Privately-Owned Firearms [Letter written August 28, 2014 to Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, Chief of the

The military cannot legally do anything to prevent the lawful acquisition, ownership, and carrying of privately-owned firearms and ammunition.¹⁴⁷ However, the memorandum allows commanders to approach service members and consult with mental health professionals if they believe the service member presents a risk of self-harm or harm to others. While the storage of ammunition and firearms must be completely voluntary, it is a measure that allows commanding officers to become involved if they notice a problem.

In addition to the memorandum, there has been some level of “gatekeeper” training among chaplains and military personnel since 2009 with the Applied Suicide Intervention Skills Training (ASIST) program.¹⁴⁸ The training does appear to be effective in showing people how to recognize warning signs of suicide.¹⁴⁹

Service members also have access to mental health care providers who screen them for mental health problems. Thousands of chaplains, social workers, and mental health counselors provide aid to service members, and mental health screening has been a common practice for all service members since before the Persian Gulf War.¹⁵⁰ Pre- and post-deployment screenings have continued since 1998, but less than 40 percent of service members answer screening questions honestly.¹⁵¹ The military has tried to combat this by screening all service members during primary care appointments called RESPECT-Mil. Despite this, the issue of honesty for screening questions remains a problem.

In addition to the above, the military has also set up a call center and benefits website called Military One Source (MOS). It is a free service to active service members available by phone or through their website that advertises tax services, training, and deployment tools.¹⁵² In 2018 Executive Order 13822, the Trump administration extended the use of MOS for veterans for one year following the end of service.¹⁵³ Extending their counseling resources, MOS works with the Military Crisis Line, run by V.A. health care.

National Guard Bureau]. <https://www.dspo.mil/Portals/113/Documents/Guidance-for-Commanders-and-HP-in-DoD-on-Reducing-Access-to-Lethal-Means.pdf>

¹⁴⁷ See Prohibition on infringing on the individual right to lawfully acquire, possess, own, carry, and otherwise use privately owned firearms, ammunition, and other weapons, 111th Congress, Public Law 111-383, §1062.

¹⁴⁸ Army Public Affairs. (2009, December 3). *Army Approves Suicide-intervention Training for Leaders*. https://www.army.mil/article/31263/army_approves_suicide_intervention_training_for_leaders

¹⁴⁹ Burnette, C., Ramchand, R., & Ayer, L. (2015). Gatekeeper Training for Suicide Prevention: A Theoretical Model and Review of the Empirical Literature. *Rand Health Quarterly*, 5(1), 16.

¹⁵⁰ Lee, D. J., Warner, C. H., & Hoge, C. W. (2018). Screening for Mental Health Disorders in the Military. In L. Roberts & C. Warner (Eds.), *Military and Veteran Mental Health* (pp. 117-127). New York, NY: Springer.

¹⁵¹ Warner, C. H., Appenzeller, G. N., Parker, J. R., Warner, C. M., & Hoge, C. W. (2011). Effectiveness of Mental Health Screening and Coordination of In-Theater Care Prior to Deployment to Iraq: A Cohort Study. *American Journal of Psychiatry*, 168(4), 378-385.

¹⁵² Military OneSource – U.S. Department of Defense. (2020). *Welcome to Military OneSource*. <https://www.militaryonesource.mil/>

¹⁵³ Exec. Order No. 13822, Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life, 3 C.F.R. (2018).

The Presidents who have presided over the Global War on Terror have taken various actions to combat suicide rates among service members and military veterans. For example, President Bush signed Executive Order 13426 in 2007, which created a task force to investigate overall health care quality, including mental health care, within the V.A. In response to the investigation, the Bush administration increased funding to the V.A. by tens of billions of dollars, allocating \$252 million alone to research on post-9/11 veterans and trauma.¹⁵⁴ President Obama continued to support research and efforts to combat veteran suicide. The Veterans Access, Choice, and Accountability Act of 2014 was the first to allow veterans to avoid chronically long wait times at the V.A. by seeking help from non-VA health care entities. The VA budget continued to increase by billions of dollars under the Obama administration, with \$7.2 billion for mental health care alone and hundreds of millions spent on increasing veterans' access to mental health care professionals.¹⁵⁵ President Trump continued the trend of increasing the budget of the V.A. and extending access for veterans. The 2020 V.A. budget has a mental health care budget of \$9.5 billion alone, with plans to increase it to \$10.9 billion by 2022.¹⁵⁶

The VA has also implemented numerous new programs and resources for veterans to combat increasing suicide rates. In 2018, the V.A. initiated the National Strategy for Preventing Veteran Suicide through a 10-year mission plan, which states, the “V.A. has embraced a comprehensive public health approach to reduce Veteran suicide rates, one that looks beyond the individual to involve peers, family members, and the community.”¹⁵⁷ It proposed a series of 14 long-term goals. They outline plans to change public and veteran attitudes about mental health and suicide, ramp up preventative services like reducing access to lethal means, promote suicide prevention as a core component of health care, and increase and improve research and surveillance of suicide. The strategic mission has already led to the implementation of universal screening. By October 2018, the VA screened 2.8 million veterans for suicidal ideation, with 3 percent responding in the affirmative.¹⁵⁸

In addition to these new strategies, the V.A. has also promoted, adopted, or implemented many other programs. For instance, the REACH VET Program determines which veterans may be at risk for suicide. Begun in 2017, it uses a predictive model for health records to flag possible suicide risk as quickly as possible, and early assessments of

¹⁵⁴ Office of Public and Intergovernmental Affairs. (2008, February 4). *VA Requests \$94 Billion for Veterans in FY '09 Budget*. U.S. Department of Veterans Affairs.

<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=1449>

¹⁵⁵ Office of Public and Intergovernmental Affairs. (2014, March 4). *Care and Benefits for Veterans Strengthened by \$164 Billion VA Budget*. U.S. Department of Veterans Affairs.

<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2528>

¹⁵⁶ U.S. Department of Veterans Affairs. (2020, February). *FY 2021 Budget Submission - Budget in Brief* (Rep. No. BiB-1). <https://www.va.gov/budget/docs/summary/fy2021VAbudgetInBrief.pdf>

¹⁵⁷ Office of Mental Health and Suicide Prevention. (2018). *National Strategy for Preventing Veteran Suicide 2018-2028*. U.S. Department of Veterans Affairs.

https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

¹⁵⁸ Office of Mental Health and Suicide Prevention. (2019a).

the system were positive.¹⁵⁹ Concierge for Care is an ongoing initiative that contacts new veterans preemptively. Those among V.A. staff members who sign up for the initiative receive a list of new veterans and try to contact them within a month of their exit from the military. The Veterans Crisis Line began in 2007 and has provided 24-hour access to free calls, texts, or online chats with health care professionals to all military personnel, veterans, and their families. Alongside these programs, the V.A. spent an additional \$12.2 million on suicide prevention outreach programs in 2018 and 1.6 times that in 2019.¹⁶⁰

It is clear the military, government, and V.A. are deeply concerned with suicide among service members and veterans. There are many resources and programs available to members of the Armed Forces past and present, along with funding for research.

Appendix II: Recommendations

The DoD and the V.A. have invested in and developed tremendous resources to help service members and veterans. However, these are not nearly enough. For instance, a recent *New York Times* article revealed findings from a 2017 U.S. Special Operations Command (SOCOM) suicide report disclosing firsthand reports of service members viewing suicide prevention classes as merely obligatory but not serious.¹⁶¹ Worse, commanders appeared insincere when tasking service members with seeking mental health resources, while others reported the military institution treated those who sought help like criminals. If the report is representative of other branches of service, then no manner of additional funds or programs could be effective without taking other preventative measures seriously. The VA is not without similar problems. A report by the U.S. Government Accountability Office in 2018 found the V.A. failed to spend millions of dollars set aside for suicide prevention outreach.¹⁶² Worse, 31 percent of “denied or rejected non-VA emergency care claims were inappropriately processed” in 2017, meaning veterans had to take on the financial burden of health care for an incredible sum of \$716 million.¹⁶³ Such revelations warrant action, and here I make some recommendations.

Apart from the need to hold government, military, and V.A. leadership accountable for managing resources and funds, it is vital to determine what other steps the DoD, the V.A., and the public need to take. The post-9/11 veterans who were surveyed by IAVA

¹⁵⁹ Richman, M. (2018, September 20). *Study evaluates VA program that identifies Vets at highest risk for suicide*. U.S. Department of Veterans Affairs. <https://www.research.va.gov/currents/0918-Study-evaluates-VA-program-that-identifies-Vets-at-highest-risk-for-suicide.cfm>

¹⁶⁰ Wilkie, R. (2019, January 14). OP-ED: The VA is making real progress on suicide prevention for veterans. <https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=5177>

¹⁶¹ Turse, N. (2020, June 30). U.S. Commandos at Risk for Suicide: Is the Military Doing Enough? *The New York Times Magazine*. <https://www.nytimes.com/2020/06/30/magazine/special-operations-suicide-military.html>

¹⁶² Draper, D. A. (2018, November). *Report to the Ranking Member Committee on Veterans' Affairs, House of Representatives - Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation* (Rep. No. GAO-19-66). <https://www.gao.gov/assets/700/695485.pdf>

¹⁶³ Office of Audits and Evaluations. (2019, August 6). *Veterans Health Administration: Non-VA Emergency Care Claims Inappropriately Denied and Rejected* (Rep. No. 18-00469-150). <https://www.va.gov/oig/pubs/VAOIG-18-00469-150.pdf>, p. i.

suggested the need to reduce bureaucracy for access to care, reform hiring and firing practices to remove ineffective and inefficient employees, expand specialized health care, employ more post-9/11 veterans, and update the technology at V.A. medical care centers in general.¹⁶⁴

President Obama's 2014 Choice Act began the shift towards holding negligent or harmful V.A. employees accountable with attention to firing practices. The VA Accountability and Whistleblower Protection Act of 2017 enhanced the accountability of all V.A. employees while providing legal protections for whistleblowers who speak up against malpractice—perhaps ensuring these legal avenues for clearing out bad apples in the V.A. system could continue to improve the overall system.¹⁶⁵ Moreover, with the V.A. budget soaring even higher year after year, it is possible to update the healthcare system's technology, create new positions to serve post-9/11 veterans, and expand specialized health care while also reducing harmful bureaucracy that hinders access to medical care.

Next, the V.A. and the military must consider expanding outreach programs and community efforts. Resilience training primarily targets individual health and fortitude appears useful, but targeted outreach programs within communities can enhance it. Just as different military branches have different experiences and cultures within the broader military, so too do the communities in which veterans find themselves after service. The VA ought to create a plan to engage local communities with some leeway for addressing the specific needs of veterans in those locations.

To reduce the frequency of exposure to traumatic events overall, the military ought to limit deployments and enhance screenings regarding their scope and frequency. Reports suggest the screenings have limited efficacy; however, they ought to still warrant serious consideration. Although the loss of a military career or even a significant role change could itself prove deleterious for service members, the consequences of deployments after multiple TBIs, the development of PTSD, or other injuries are clear. Of course, part of improving screening efficacy would also entail improving help-seeking attitudes for health issues. To do so, the military must also make changes to its organizational culture. It must shift away from its emphasis on individual responsibility as a model for blame in favor of one that places moral responsibility on collectives or the military organization itself. The culture that overwhelmingly produces feelings of self-blame, guilt, and weakness amid service members must change. Change may be difficult; political scientist Neta Crawford writes of the difficulty of making changes to organizational frameworks as the “problem of ‘many hands’” since no one individual can alter the cultural products of the organization alone.¹⁶⁶ However, the military organization is a “collective ... moral agent,” and it should be possible for the organization to alter its moral frames via a collective effort.¹⁶⁷

¹⁶⁴ Britch. (2020).

¹⁶⁵ Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, 115th Congress, Public Law 115-41, § 1094.

¹⁶⁶ Crawford. (2013), p. 317.

¹⁶⁷ Crawford. (2013), p. 315.

By extension, the masculine culture promoting strength and machismo at the expense of help-seeking also needs to change. Research shows positive attitudes towards therapy are highly predictive of help-seeking for mental health crises.¹⁶⁸ If the military and V.A. want to promote this behavior, it will require an overhaul of the military culture to promote positive attitudes towards help-seeking, framing it as a strength and a force multiplier.

In addition to the above changes, both the military and the V.A. must continue to pour research into protective factors against suicide. For example, religion and high religiosity among veterans and service members often serve as protective factors.¹⁶⁹ More importantly, religiosity may alleviate moral injury if used as a protective system, coping mechanism, or spiritual tool for finding forgiveness.¹⁷⁰ In addition to religion and these other protective factors, any sort of social resource or cultural package that produces self-forgiveness could be beneficial, as research found self-forgiveness to be among the most efficacious protective factors.¹⁷¹ Moreover, those in the military who felt a sense of cohesiveness, quality leadership, and job satisfaction also tended to be at a lower risk for suicide.¹⁷²

¹⁶⁸ Porcari et al. (2017).

¹⁶⁹ This is not always true as religion could be the source of moral dissonance in cases or could enhance feelings of not belonging to a moral community, which may precede suicidal behaviors.

¹⁷⁰ For example, see Hufford, D. J., Fritts, M. J., & Rhodes, J. E. (2010). Spiritual Fitness. *Military Medicine*, 175(8S), 73-87 or Malott, J. D. (2015). *Morally Injurious Experiences, Meaning, and Spiritual Functioning in Iraq and Afghanistan Veterans* (Doctoral dissertation, Fuller Theological Seminary, School of Psychology, 2015). Ann Arbor, MI: ProQuest LLC.

¹⁷¹ Bryan, A. O., Theriault, J. L., & Bryan, C. J. (2015). Self-forgiveness, Posttraumatic Stress, and Suicide Attempts among Military Personnel and Veterans. *Traumatology*, 21(1), 40-46.

¹⁷² Griffith, J. (2015). Suicide in the U.S. army: Stressor-strain hypothesis among deployed and nondeployed Army National Guard soldiers. *Journal of Aggression, Conflict and Peace Research*, 7(3), 187-198.