What is veteran suicide prevention really about? Questions from the community to researchers

Brandy M. Fox

Department of Health Care Ethics, Saint Louis University, St. Louis, MO, United States

ABSTRACT

Military veterans are one of the most researched groups in healthcare in the United States. This population has extremely high rates of suicide attempts and completions. Despite increasing research focus, millions of dollars in funding, and being designated as a high clinical priority, rates of suicidal behavior continue to rise among veterans. Veterans are extremely concerned about this trend and critical of some suicide prevention projects. This study engaged 20 veterans who are connected to individuals within the military community who have attempted or completed suicide. Through semi-structured interviews, participants expressed a profound sense of disconnection from existing policies, treatments, and strategies aimed at preventing veteran suicide. During the course of the interviews, participants posed their own questions: Why is the public really concerned about veteran suicide? Why won't the public recognize its part in the veteran suicide epidemic? Why won't the medical industry listen and collaborate with us? This study underscores the critical need for all stakeholders involved in veteran suicide prevention to reflect on these concerns and to incorporate veterans' insights into future prevention strategies, creating a more responsive and effective approach.

Correspondence: Brandy M. Fox, Department of Health Care Ethics, Saint Louis University, 3545 Lafayette Avenue, St. Louis, MO 63104, United States.
Tel.: 3077524831 - Fax 5016617967
E-mail bfox@uams.edu

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Introduction

Media coverage of suicide can have a significant impact on individuals, communities, governments, organizations, and families. Media tend to cover suicides of military veterans more often and in a more negative light compared to civilian suicides, forging a significant link between "trauma" and "veteran" in the public imagination (Parrott et al., 2022; Schuman et al., 2016). This association is not completely fanciful. Veterans are 1.5 times more likely to complete suicide than people who have never served in the military (Steinhauer, 2019). Veterans understand and recognize the severity of high rates of suicide in their community, and they expect the media to accurately cover veteran suicide in order to help facilitate prevention efforts (Fox, 2021). This often means listening to military veterans about the causes, barriers to treatment, and potential solutions for suicidal individuals.

Background: Suicide among military veterans

A US veteran is defined as, "a person who served in the active military, naval, air, or space service, and who was discharged or released there from under conditions other than dishonorable" (Veterans' benefits, 2011). Veterans make up roughly seven percent of the US adult population (Vespa, 2020). Despite this, approximately one in every five deaths by suicide in the United States is a veteran (Schuman & Schuman, 2016). In raw numbers, over 6,000 US military veterans have completed suicide almost every year from 2001 to 2021 (OMHSP, 2023). Yet despite increasing attention, funding, and political support for veteran suicide prevention, the number of completed veteran suicides continues to increase (OMHSP, 2023). This epidemic is so well-known that recruiters for the Islamic State use

veteran death statistics to boast about how successful their armies are:

> America, you claim to have the greatest army history has ever known. You may have the numbers and weapons but your soldiers lack the will and resolve, still scarred from their defeat in Afghanistan and Iraq. They return dead ... or suicidal ... (And No Respite 2015, cited in Rarm, 2018, p. 7).

Claims such as these are both alarming and true. There is a desperate need to find better suicide prevention strategies specific to the US veteran population and to disseminate those strategies.

Veterans have a unique place in the American medical establishment. The United States has a healthcare system specifically for this population which has taken the lead on veteran suicide prevention. Housed under the federal government's Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) is the biggest healthcare system in the US (VHA, 2023). In addition to providing care, the VHA has a mission to conduct health research (Panangala & Sussman, 2023). Thus, many American veterans are familiar with being research participants in conjunction with receiving health care. The VHA states that their highest clinical priority is preventing veteran suicide by taking a public health approach to suicide prevention (OMHSP, 2018). The VHA's National Strategy for Preventing Veteran Suicide was designed to be evidence-based and aims to coordinate health care for veterans among multiple participants including community-based groups, media producers, and local health care providers.[1] The strategy focuses on addressing the trifecta of mental health, substance abuse, and suicide. It involves striving for zero suicides and mainly works through identifying risk factors and increased monitoring of individuals who may be at a heightened risk of suicide.

Current prevention strategies: Underlying ethics

Those who work in suicide prevention have both an explicit and implicit ethical framework. The explicit framework is readily expressed in policies and best practices. The VHA's National Strategy claims that "preventing Veteran suicide as our highest clinical priority[...]. We know that suicide is preventable" (OMHSP, 2018, p.1). Prevention strategies work most often by invoking the ethical principles of nonmaleficence and beneficence to justify treating suicidal people (Sjöstrand et al., 2015). This beneficence comes from a medical provider whose job it is to correct the suicidal person's inaccurate thoughts, feelings, or desires, often by using labels of mental illness. Psychiatrists explicitly evaluate a patient's autonomy and decision-making capacity (Sjöstrand et al., 2015). This "medical model" of suicide prevention posits that the majority of suicidal ideation, attempts, and completions are pathologies which are the result of biological/neurochemical imbalances, inadequate psychological coping mechanisms, and/or lack of mental health support (den Hartogh, 2016; Hacking, 2008; Katz, 2012). In this view, the appropriate treatment for suicidal individuals is within the healthcare system, working with clinically trained personnel.

The medical model constitutes an inherent tension when it comes to suicide prevention. On one hand, the model foregrounds and respects the patient's views on quality of life and treatment preferences (i.e., "autonomy") and treats the patient's viewpoint as the most important. On the other hand, suicide prevention inverts this hierarchy by encouraging and sometimes even forcing patients to de-prioritize what they want for themselves and privileges the opinions and desires of others (Fitzpatrick, 2018). This inversion is justified by appealing to an "objective" best interest standard that prioritizes "bare life," i.e., the contention that as long as a person is alive, they are far better off than if they were dead, regardless of their quality of life (Agamben, 1998).

What are the implicit ethics of suicide prevention? At first glance, it may seem like an unnecessary question. However, it is important to articulate which values and worldviews are privileged when promoting suicide prevention. Critical suicidologist, Jennifer White (2016, p. 336), argues that this is not often done and that these prevention frameworks "are predicated on particular values and assumptions, and all are driven by specific ontological and epistemological commitments (including the stance of so-called value neutrality), even though they are not always explicated."

Suicide prevention strategies often view suicide as a monolith and are tailored to a specific group of ideal suicidal subjects. The ideal suicidal subject is thus someone with a mental health diagnosis who is willing and able to work within a medical model to correct what are either irrational or mistaken beliefs about their own life and its quality (Baril, 2020).

Veterans often do not fall into this configuration of an ideal subject, for various reasons. Many veterans do not want a psychiatric diagnosis, are suspicious of pharmaceutical solutions, or believe that suicide is a realistic, achievable option to end their suffering. Utilizing suicide prevention strategies aimed at ideal suicidal subjects, therefore, leaves out many individuals who need help. These people may be better helped by incorporating aspects from what Kristian Petrov (2013, p. 360) calls "reflexive suicide prevention":

> Reflexive suicide prevention efforts—as opposed to technocratic and bio-political ones—means that one tries to meet the suicidal individual openly and fully. Death and grief are emphasized as human conditions, and the potential suicidality in everybody is recognised instead of separating diseased from healthy.

This approach allows the individual who is feeling suicidal to remain within their own moral communities; they are not required to surrender control of their treatment to medicine or other authorities.

Veteran suicides are not always the result of inescapable emotional reactions or organic disorders. Some deaths by suicide can be interpreted as chosen reactions to unacceptable social and political circumstances. Therefore, some potential solutions to suicidality must address these non-medical dimensions.

Veterans often need a space to demonstrate impacts of the emotional scars and moral injuries they received as a direct result of military service and to take responsibility for actions that may have been technically legal and followed the rules of engagement but that continue to haunt them. Moral injury, as described by Litz et al. (2009, p. 696), happens when veterans "are unable to contextualize or justify their actions or the actions of others and are unable to successfully accommodate various

[1] Veterans are not required to receive care through the VHA. However, the VA does take responsibility for heading veteran suicide prevention efforts (OMHSP, 2023).

morally challenging experiences into their knowledge about themselves and the world."

I served in the US Army as an officer for four and a half years. During that time and since, I have known many service members and veterans who have attempted or completed suicide. Given the large emphasis placed on suicide prevention, I was troubled and perplexed when I learned that rates of veteran suicide keep increasing. There seemed to be a disconnect between policies and results. Therefore, I wanted to talk to my fellow military veterans to learn more about why they think this is the case and how we can do better suicide prevention research.

Materials and Methods

Study design

This article details incidental results from a previous study that employed verbal, semi-structured interviews with individual veterans to explore their perspectives on veteran suicide and its prevention (Fox, 2021). The aim of the first study was to describe the ways current suicide prevention strategies are inadequate to meet the needs of the veteran community and to offer suggestions of how to improve these strategies. However, something else emerged from the research participants themselves: questions from the community to those who study them. These questions surfaced as themes while reading through interview transcripts. The themes were significant enough to warrant their own analysis.

The choice of a qualitative approach for the initial research design aimed to capture nuanced insights directly from veterans, acknowledging the shared experience within the veteran community (Bloomberg & Volpe, 2016). My identity as a veteran facilitated trust and openness in dialogue as I interviewed American veterans with direct or indirect experiences of military-related suicides, and my background as a PhD candidate trained in qualitative research reassured participants about the study's technical rigor.

The interviews were designed to gather honest opinions on suicide prevention from veterans, utilizing an open-ended question format refined through pilot testing. Ethical approval of the study was obtained from the Saint Louis University Institutional Review Board. By fostering an environment of trust, respect, and participant autonomy, I sought authentic narratives surrounding veteran suicide while prioritizing the welfare of those involved.

Sample

I conducted semi-structured interviews with 20 veterans acquainted with individuals in the military community who attempted or completed suicide. Demographically, 15 males and five females were interviewed (75% male, 25% female). Nineteen of the interviewees identified as white (95% of sample) and one identified as Hispanic (5% of sample). Specific military branch representation included two Air Force, two Navy, five US Marine Corps, and 13 Army veterans. Two veterans each served in two branches throughout their career. There were six officers (30% of the sample) and 14 enlisted (70% of the sample) veterans. Number of years in military service ranged from four to 29 years, with the average length of service being 11.4 years (SD±7.9 yrs). Fourteen (70%) of these individuals had deployed. The age range of the participants was 32 to 59 years old, with a mean age of 42 (SD±7.6 yrs). Each person had been impacted by suicide in their personal or professional lives, including first-hand knowledge and experience of suicidality within his/her social network. Participants primarily served during two eras of American military conflict: the Gulf War (1990-1991) and Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) (2001-2021) (Torreon & Miller, 2024). I employed purposive sampling, specifically criterion, and snowball sampling, as outlined by Bloomberg & Volpe (2016). To be eligible, participants had to: 1) be a veteran of the US armed forces, 2) know someone within the military or veteran community who attempted or completed suicide, 3) be fluent in English, and 4) be willing and able to consent to participate in the research and complete an interview. In addition to the twenty participants who qualified for the study, there were two interested individuals who were not interviewed—one active-duty military member and another without relevant connections.

Procedures/recruitment

Recruitment primarily occurred through Facebook advertisements within four veterans' groups and referrals within veterans' social networks. This method aimed to access diverse veterans (across branches and eras) and establish credibility with veterans wary of discussing the emotional and controversial subject of veteran suicide prevention.

Data collection

Potential participants who expressed interest contacted me via e-mail or Facebook message. I wrote back and established a time to speak either by telephone or in person at a place of the participant's choosing. At the appointed time, I verbally reviewed inclusion criteria to confirm eligibility for the study. Upon confirmation, I obtained verbal consent from each participant. Next, I conducted and digitally recorded interviews either over the phone or in person. The interviews were subsequently transcribed verbatim by a professional transcriptionist. Each participant was assigned a pseudonym. I also made notes during the interviews. Interview durations ranged from 25 minutes to two hours, depending upon participants' personalities, engagement with the topic, and comfort level with me as interviewer. One participant requested a copy of their interview transcript.

Data analysis

Data analysis followed a deductive thematic assessment approach in three stages: individual coding, categorization, and theme development (Lochmiller, 2021). Evaluation started on each transcript as soon as it became available, typically within one to two weeks of recording. I immersed myself in the data by reading each transcript at least twice, identifying emerging concepts. Initial codes were generated from these concepts, followed by categorization through subsequent transcript readings, guided by previously highlighted passages (Lochmiller, 2021).

During initial categorization, I noticed numerous instances during the interviews when participants directed the conversation towards specific examples or complaints that they thought illustrated why suicide prevention for veterans has not been very successful. These comments did not quite fit under either of my original research questions, but they happened so frequently that these lines of inquiry became impossible to ignore. Upon secondary review for this study, these comments were further re-

fined into themes using constant comparison, where data were iteratively sorted, matched, and compared as above (Glaser & Strauss, 1967). During this phase of the analysis, three thematic questions emerged in the data: i) Why is the public concerned about veteran suicide?, ii) Why won't the public recognize its part in veteran suicides?, and iii) Why won't the medical industry listen to and collaborate with us?

Results

Question 1: Why are you really concerned about veteran suicide?

Several participants questioned the motives behind suicide prevention as it is currently practiced. These concerns can be broken down into two categories: Participants felt 1) that they were sometimes used as tools for public relations and 2) that there were significant financial incentives for institutions and individuals to care about veteran suicide prevention.

Veterans are not tools for public relations

Participants made several disgruntled comments indicating that they thought veterans are frequently used as advertising or political tools for the benefit of outside individuals and not the veterans themselves. For example, Clarissa, a former enlisted military police officer, described how many politicians looking for votes see veterans as a safe, perennially popular group to support:

> [W]ell, if you're going to go for the soft spot to, like, politicians, if they really want to get people on their side, they'll be, like, "Yeah, look at all the stuff I do for veterans, because the veterans!" There's like a status that comes with veterans, and so there's the, "Oh my gosh, it's the veteran!"

Paul, who served in the Navy, also mentioned the benefits politicians get from helping veterans and brought up how media amplify this effect:

> But I think part of the problem is the way that the media reports it, and then our senators, and Congress, and all the wheels that make things go around. It's votes. It's ratings [pause] but that's the power that the media can have on policy. And every senator and congressman knows if they get a phone call from somebody, they better send an aid to go answer that because it will be all over the newspapers if they don't.

Participants such as Paul felt that politicians are responsive to veteran issues, especially mental health care, not because they want to help veterans, but because they fear losing votes from constituents if they are portrayed as indifferent to veteran suffering and unwilling to advocate for services for veterans.

There are financial incentives to care about veteran suicide

Dale, who is in his early 40s, talked about a financial incentive in supporting suicide prevention for veterans: "That is a big problem: a lot of people claim to help veterans, but they just throw that on there for tax purposes I think." Dale went on to express his frustration at trying to find help from various local agencies when he was struggling and being told he was not eligible because he was a single male. Dale felt that while different programs were advertised as being for veterans, they were actually aimed at specific sub-groups, for example, homeless vets, those with children, or female veterans. Overall, participants believed that agencies claiming to support veteran suicide prevention had more narrow interests that de-prioritized the type of help veterans were seeking.

Hans, a former Army officer, made a point to talk about how upsetting he found this perceived pattern:

> Yeah, and I think it's sort of, it's not something you asked about, but something I wanted to mention, there should be more, almost regulation, I think, on nonprofits and how they can become established and stand up and get their nonprofit status when they are geared towards veterans, because I see so many, and I feel like it's exploitation of a certain issue, especially because I've been around a lot of them, and I'm like, "You aren't doing anything. You're selling merchandise." And you're, whoever founded the nonprofit, gets a lot of praise and attention, but you're not doing anything. They're going to pump it back into their advertising.

Hans also told a story about when he was transitioning from active duty to being a civilian: He visited and offered to work at several pro-veteran nonprofits and Congressional offices as an unpaid intern, hoping to find a supportive environment to ease his transition into civilian life. However, the purportedly "veteran-friendly" offices and organizations very rarely got back to him, and those that did were unable to show what they were actually doing to help struggling veterans. Experiences like these made Hans suspicious that some organizations were only claiming to help veterans in order to reap financial rewards.

Question 2: Why won't you recognize your own part in veteran suicides?

Many participants felt that stopping deaths from suicide was not enough; it was important to these veterans that other people know the trauma and events behind suicide and recognize the part society plays in the current epidemic. Some participants sensed that certain members of the public were insincere when they professed a "Support the troops" mentality, because that support did not include an understanding or recognition of what experiences "the troops" actually had. This perceived lack of recognition among civilians extended to what some veterans interpreted as dismissal of the transformative experiences military members had during their service and failure to understand the moral impacts of military service. This sentiment was expressed through three subthemes.

Subtheme 1: The public does not really want to know about military experiences

Jacob, who served in Iraq, talked about how a superficial understanding of what veterans went through while on active duty leaves out critical parts of the story:

> [T]hose stories are not as simplistic as they tend to make them [...]. The problem is I don't think anybody wants

> to understand it [a veteran's personal experience] in those more complex terms, because that means you actually have to think. You have to understand. You have to take an interest in those things to an extent more than you probably want or have the time to.

Similarly, Dale, a former infantryman, noted that a lot of people don't want to know the details of what actually takes place on deployment—something he called "the ugly side":

> I think the thing with veteran suicides is the overall trauma. It becomes…. It's almost like a dirty word with us. You know, one of those things that society doesn't want to admit to because, yeah, everybody loves a man in uniform. Everybody loves a person in uniform. Everybody respects a man or woman in uniform, but they don't want to look at the ugly side of it.

Dale grasped that even when civilians did think about the wars in the Middle East, they failed to wonder or acknowledge what specific actions military members were exposed to or were asked to do and how traumatic those situations could be.

Subtheme 2: Civilians do not want to see how much military service changes a person

Ruby, who deployed to Iraq, also talked about the civilian-military gap and how in her experience, most citizens have trouble accepting that returning military folk are changed:

> People talk about war. They talk about all the stuff. And yeah, we sent our men and women, but no one really truly goes, "Yeah, they're not going to be normal." Only good healthcare clinicians do that. Most people are like, "They'll just get over it." I'll tell you, even now, it still impacts my personality because it's hard to get out of that… [pause] You know, people don't understand, civilians don't understand….

By the same token, Jacob, who enlisted out of high school, talked about his perception of how the majority of America does not want to hear about why veterans come home different from their pre-military self:

> You have the general society that wants to thank you for your service and know in general what you went through, but they don't want to know the broad expanse to understand, if they know you, they're a family member, relative, or close friend, the differences. They don't necessarily want to know all the reasons why you've changed, or to them, your mindset or your actions, what they knew you to be.

Both Ruby and Jacob believed that without contextual understanding of how veterans came to be suicidal, prevention efforts would be inadequate.

Subtheme 3: People and institutions are not acknowledging the moral injury inflicted by the wars in Iraq and Afghanistan

Moral injury can happen when one's values or moral rules are violated, sometimes described as "a torture to one's conscience," resulting in emotional, spiritual, social, and psychological repercussions (MacLeish, 2019, p. 281). Moral injury can also be caused by feelings of betrayal by what was once considered a dependable, ethical teammate or institution (Barr et al, 2022; Molendijk et al, 2022). Several veterans spoke about how they had once trusted policymakers to make wise decisions about how to use the military. Veterans experienced emotional distress when they realized this was not always the case. Hans, for example, pointed out how his faith in governmental policy decisions was shattered by what he experienced:

> So, I was raised to be sort of right wing, conservative and all that, and I kind of just drank the Kool-Aid, and thought I was that way, until I actually experienced stuff. Then I was super bitter, because I would go back and people would say, like, "Well, you're doing it for our freedom." I'm like, "No, this doesn't really matter for our freedom at all." [O]verall strategy or failure of strategy in my opinion just really hit me once I was there and trying to do the mission, and that's when I really was just like, "Why are we here? What are we doing?" [W]hen you sign up, you hope that you do it because policy makers will make good decisions[...].

Most strikingly, Red talked about the moral injury inflicted by the government on veterans:

> I don't have a single friend that went to Iraq or Afghanistan that believes that it's going to do any good, and they feel betrayed. And I can't speak for all the other combat vets, but they feel betrayed. They feel that their lives, the politicians treated their lives with a very cavalier attitude, and the price they're paying for it is emotional pain. Their wives and girlfriends have no way to understand or relate to them, they feel alone, and they feel used.

Both Hans and Red found that their time overseas opened their eyes to how foreign and military policy impacts those on the ground. Each man felt deceived by an institution that he had thought was made up of the "good guys" who bring freedom and other American values to oppressed peoples. This deception contributed to an aspect of suicidality that could not be healed by medicine.

Question 3: Why won't medicine listen to us?

Finally, many participants questioned why healthcare institutions and professionals consistently did not listen to veterans' suggestions about how to prevent suicide. Several participants wondered if suicide prevention was just another way for medicine to exert power over patients. Two subthemes emerged regarding this question.

Subtheme 1: Discounting insider knowledge

Brennan, a former enlisted mechanic, spoke about how insider knowledge from veterans could be used to improve suicide prevention and how that is being hampered by what he sees as attitudinal barriers from some medical professionals:

> I think the first thing they're [clinicians] going to do is, like, "This needs to be studied, and this needs to be

> studied." And there's a bunch of us over here like, "We've already studied it on ourselves!" I can tell you this is not working, and we need to come up with a different solution. Or the professional or a doctor that's been doing it for many years and just thinks pills is the go-to: "I've got to prescribe this to do this" or "This is what we need to do."[...]We [society] have a lot of ego going on, and instead of swallowing your pride or ego and listening to the person next to you, and communicating with that person, and coming up with a joint solution, we're still back to step one, and it's unfortunate.

Brennan's frustration stems from his perception that clinicians will not value the experiences and suggestions of people from the veteran community—perspectives that he sees as being crucial for a successful suicide prevention program.

Subtheme 2: Alternative therapies are not available through traditional medical care services

Several of the veterans interviewed said they had done extensive personal research to learn more about suicide and how to help their battle buddies.[2] They expressed disappointment that some alternative therapies that have shown success in other populations were not available to the veterans through the VA. Dale, a former non-commissioned officer (NCO), reflected:

> Quite frankly, I think if your average veteran could go to the VA and get handed a dime bag that would be great. I mean, give me a Solo cup full of sweet tea and a bowl filled with some good cannabis, and I'd probably be a lot better off.

Julio, a former Marine, also thought it was important to try and help veterans via non-traditional treatments:

> I think we're on a precipice of a couple of very interesting things. If we can, a little bit side ball topic here. I've been doing some reading on things like ketamine therapy and MDMA [a synthetic, psychoactive drug also known as ecstasy or molly] therapy and the statistics on the, the amount that that helps [pause] at the very least, warrants fast tracking some further studies, in my mind. I understand the stigma behind psychedelics, but holy shit, if this does what it appears it does, I think it's immoral to not do everything that we can to move this along and make it available.

Overall, veterans felt that traditional medical hierarchies were slowing down ways to help prevent suicide, first by discounting community member knowledge, and second, by not allowing alternative therapies.

[2] "Battle buddy" has a specific meaning in the Army. Soldiers are never supposed to go anywhere alone, so wherever one person goes, their "battle buddy" accompanies them. This is for security and to act as a second pair of eyes on something unwise one might be tempted to do - anything from attempting suicide to irresponsible decisions when drinking. The "buddy" in this term indicates that it's a purely platonic relationship, exclusive of sexual or romantic entanglements.

Summary

Throughout the project, participants wondered what suicide prevention was really about. They questioned and struggled to identify ideologies and motives behind suicide prevention efforts. In addition, participants felt that suicide prevention programs leave out what was most important to veterans: that others know the trauma and events behind suicide and recognize the part society plays in the current epidemic. Finally, participants questioned whether all potential options for preventing suicide were being explored; several participants doubted that they were.

Discussion

Over the course of the interviews, participants had their own questions for society, the medical community, researchers, the public, and the media. These queries arose spontaneously throughout the interviews, from within a community that has been dealing with and thinking about their pain and losses for a long time. Almost every participant thanked me for trying to tackle the issue of veteran suicide, and several participants thought that the questions suicide prevention researchers have been asking are missing a large part of the story. During our conversations, veterans expressed that they were eager to help stem the suicide crisis. They asked questions that exposed weak areas in suicide prevention that, from their points of view, must be addressed if prevention programs are to be successful. Participants communicated that in order to be effective, prevention efforts must be done in good faith valuing the requests, epistemological knowledge, and perspectives of veterans themselves.

Concern about veteran suicide

Participants were often suspicious of the motives behind suicide prevention, believing that they were being used as advertising or political tools for the benefit of outside individuals. Participants believed that these incentives were prioritized above what the veteran community was actually asking for in terms of assistance. Veterans conveyed that they had their own ideas about how to address suicidality that were not being solicited or noted by prevention programs. The experiences they described illustrate a larger trend with mental health organizations that Costa et al. (2012) have criticized:

> In the last decade, however, mental health organizations have begun to use and rely on personal stories from users of mental health services [...] typically, about their fall into and subsequent recovery from mental illness. These stories function to garner support from authority figures such as politicians and philanthropists, to build the organizational "brand" regardless of program quality, and to raise operating funds during times of economic constraint. (p. 86)

Because of what they saw as insincere motives, several veterans thought that suicide prevention initiatives were focused on the optics of support, rather than results. Participants perceived that some organizations only professed to care about veteran suicide because it was a way to gain recognition, money, or votes. This lack of trust in entities running suicide prevention programs made veterans more skeptical and critical of the help being offered. Participants, therefore, felt that the programs were not

initiated and run in good faith and failed to center the requests and perspectives of the veteran community.

Recognition of social responsibility

A second common refrain was anger and frustration that "veterans issues" were often examined as isolated issues that are separate from society at large. While all participants were appreciative of publicity about and potential solutions to the suicide crisis, they felt that prevention programs often miss the point: They do not merely want their brothers and sisters to stop completing suicide. They wanted the public to realize that the public is part of the reason they feel this way and that the public has directly contributed to the traumatic events that many veterans are still dealing with. Participants thus spoke about how important moral accountability is in the veteran suicide crisis.

Military service inevitably takes a toll on the individuals who choose to enlist or accept a commission, which means that those who benefit from this service have an obligation to those who served (Selgelid, 2008). Many participants felt that much of the time, healthcare providers, the media, and the public didn't want to actually know what happened or care *why* so many veterans are turning to suicide. Montross Thomas and colleagues (2014) also found that the "why" of the suicide crisis is important. Their qualitative study with veterans who had attempted suicide revealed that these patients wanted clinicians who saw them holistically, which included exploring why there was a suicide attempt and how to address the underlying issues that led to the attempt (Montross Thomas et al., 2014). As this study shows, veterans sometimes suspect that they were used as unwitting instruments of misinformed foreign policy. When viewed through a medical model of suicide, feelings like this can be dismissed as nonrational or unrelated to suicidality and, therefore, do not require further exploration. The continual emphasis on stopping veteran deaths by suicide by almost any means misses the multifaceted layers of why these deaths are happening.

Participants were also frustrated because they perceived that Americans refuse to acknowledge "the ugly side." Veterans expressed that there is a huge difference between the person who entered the military and the veteran who emerges from it, and they did not feel that many civilians understood the immensity of that change. Some veterans, like Ruby and Jacob, think this hampers efforts to help veterans: Unless those providing help have a realistic understanding of what happened, they cannot offer proper resources to assist veterans. Other veteran scholars have noted this need for reconciliation with, or at least recognition from, the wider community in order for veterans to heal from suicidality (Daniel, 2016; Kelly, 2013a). This study offers further support to Kelly's (2013b) recommendation that researchers should ask veterans what types of treatment they want and then work to find ways to implement them.

Participants also conveyed that blaming veteran suicide on mental illness and substance use disorder omits a large part of the story. Beyond any physical injuries (though there were certainly many of those), participants described how they were often wounded by what they see as willful ignorance on the part of the public and political officials who sent them to war. Many participants feel that there has yet to be a public reckoning and acknowledgment that the wars in Iraq and Afghanistan did not end in victory for the US and that the wars, in fact, had devastating effects on several million Iraqi and Afghani citizens, in addition to military service members.

In his memoir about being in politics while struggling with post-traumatic stress disorder (PTSD), Army National Guard veteran Jason Kander (2022) writes,

> We felt that no one knew what we knew because they hadn't seen what we had seen; every person who opposed us became an avatar for the people who had pushed a war of choice in Iraq but denied our troops in Iraq and Afghanistan the body armor and equipment that they needed. (p. 60)

Kander is explaining his frustration at being one of the few policymakers who had military experience in the War on Terror. His memoir recounts several situations in which people responsible for making war fundamentally misunderstood what their policy decisions were translated into as actions overseas. This anger over their refusal to even wonder what part they might have played in the veteran suicide crisis eventually contributed to his suicidality (Kander, 2022).

As noted above, veterans' feelings of personal betrayal have been characterized as "moral injury" (Molendijk et al, 2022; Barr et al, 2022). Veteran and scholar Michael Yandell (2019, p. 3) describes moral injury as being about human relationships and "belonging to many people at once." Thus, healing from the moral injury that sometimes contributes to suicidality in veterans requires that the civilian community recognizes its part in facilitating moral injuries: "What we need is an account of moral injury in which the social and spiritual stakes are explicit, in which moral recovery is not a matter of individual therapy but rather of communal reconciliation that is transformative and self-reflective" (Daniel, 2016, p. 155).

Molendijk et al. (2022) recently conducted a review to contextualize the concept of moral injury, noting that interventions involving a wider social context beyond individual veterans are missing. MacLeish (2018, 2019) also argues that the collective has been conspicuously absent from discussion about moral injury and that the situation is primarily framed as an individual phenomenon. Participants' complaints about moral injury and the harmful absence of collective response confirms the conclusions drawn by Molendijk and colleagues: "[...] political failures and simplistic representations in public debates may engender a sense of perceived political betrayal and societal misrecognition, and in turn make morally injured veterans seek political compensation and societal recognition" (2022, p. 9). Part of this societal recognition involves listening to veterans about what they need to help decrease suicide among themselves, and participants in this study stressed how critical this recognition is in order to successfully deal with veteran suicide.

The medical industry

Finally, participants wanted to know why the medical industry won't listen to them. Veterans want to collaborate to stop suicide: "[...]the veteran community wants to engage in dialogue, have their voices heard, and share and find new solutions to keep veterans from going down a dark road and taking their lives" (Krause-Parello et al., 2019, p. 50). However, many veterans are finding it difficult to work with the medical community. Some research suggests that the medical industry tends to discount insider knowledge from people who are or have been suicidal (Baril, 2020; Michel et al., 2002; Taylor, 2019). Several participants conveyed how they had personally experienced this marginalization by healthcare providers.

The majority of participants had done their own research about veteran suicide. They had a variety of ideas about different types of groups, treatment modalities, and possibilities for addressing the suicide crisis that stem from firsthand experiences, either as being suicidal themselves or providing support to colleagues who were suicidal. Dale, Julio, and Brennan, for example, drew on their personal experiences and academic literature to advocate for potential treatments for veterans who were suicidal. However, each felt that the medical community disregarded these suggestions because they didn't come from a paradigm of evidence-based, professional medicine.

In contrast, participants concluded that suicide prevention efforts constructed without regard for solutions from veterans were ineffective. Utilizing ideas that veterans propose could be framed as what Redvers (2019, p. 20) refers to as evidence-informed practices: "verbal and written data and experience to assess response and continued applicability and safety in the context of a holistic model of care." Several authors have also argued that the veteran community is resourceful, suggesting that suicide prevention programs should listen to them and make use of their strengths and insight into the problem (Monteith et al., 2020; Springer, 2020; Thomas & Taylor, 2020). Many participants expressed that they hoped that this study would be another step towards having their ideas and voices heard about how to improve suicide prevention.

Study limitations, future directions

This study was based on a relatively small number of interviews (n=20) which means it may not speak for the wider veteran community. None of the participants expressed current suicidal ideation, though some did report that they had formerly been suicidal. Thus, the data does not reflect the opinions and views of people who are presently considering suicide. Gathering data from veterans currently wrestling with suicidal thoughts could provide different insights and suggestions for suicide prevention.

Also, the interviews took place at the beginning of what turned out to be a global pandemic, a time of great social change for all interviewees. It is unknown how this impacted participants' responses to or interpretations of the interview questions.

In addition, data were gathered from mainly White respondents (19 of 20), so these results may or may not apply to veterans who are members of other racial or ethnic groups. Similarly, all participants served in either the Gulf War era or OEF/OIF era, so it is unknown if these results apply to veterans from other service eras. I appeared to reach thematic saturation for recommendations and themes provided, but further work within different populations, including gender and age, may be warranted.

Transcripts of the conversations were not reviewed by each interviewee. In future studies, this step could be added to ensure the participants got their ideas and points across during the interview.

Because most of the interviews took place via telephone, I was unable to obtain visual clues or observations about the participants; however, these observations were not considered to add significantly to the data.

Conclusions

Participants wanted social recognition that involves listening to veterans about which resources they need to best decrease suicide among themselves. They also desired accurate media coverage of veteran suicide and prevention strategies, including those stories that do not feature the ideal suicidal subject, for example, someone who disengaged with the healthcare system and used the wider veteran community to help with their suicidality. Principally, in order to be successful, suicide prevention must be done in good faith attending to the requests, embodied knowledge, and perspectives from within the veteran community. All entities involved in suicide prevention among military veterans can learn by reflecting on how best to incorporate the implications into future prevention activities.

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