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Leader Perspectives on Managing Suicide-related Events in Garrison

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ABSTRACT: Leaders who have personally experienced the aftermath of a suicide-related event can provide important lessons and recommendations for military leadership and policymakers. This paper executes a thematic analysis of interviews with leaders, chaplains, and behavioral health providers who responded to garrison suicide-related events and explores leader decision making related to memorials, investigations, and readiness.

Keywords: suicide postvention, garrison, military leader, chaplain, behavioral health provider

Suicide is a significant threat to military readiness and is a preventable form of death. In the last decade, suicide has become a leading cause of death for service members, claiming more lives than combat and transportation accidents.[1] The suicide rate among active-duty service members increased from 20.3 members per 100,000 in 2015 to 28.7 members per 100,000 in 2020.[2] Collectively referred to as suicide-related events, suicides, suicide attempts, and suicidal thoughts requiring intervention have ripple effects extending beyond any one individual. Researchers estimate every death by suicide impacts 135 people.[3]

Clearly, these disturbing and tragic events reverberate across the community, from leaders and unit personnel to friends and family members. Supporting those affected in the wake of a suicide-related event is called *postvention*. Suicide postvention targets those potentially affected by the event to help mitigate behavioral health concerns in the aftermath.[4] Postvention refers to support in response to suicide but may also apply to support in response to a suicide attempt or other suicide-related event. Postvention responses are shared by a team of unit leaders, chaplains, and behavioral health providers. This team is further supplemented by civilian nonmedical counselors (military and family life counselors). Leaders faced with managing these events must sustain the morale and readiness of their troops while acknowledging each

1. Armed Forces Health Surveillance Center, "Surveillance Snapshot: Manner and Cause of Death, Active Component, U.S. Armed Forces, 1998–2013," *Medical Surveillance Monthly Report (MSMR)* 21, no. 10 (October 2014): 21.

2. Department of Defense (DoD), *Annual Suicide Report* (Washington, DC: DoD, 2020), 6.

3. Julie Cerel et al., "How Many People Are Exposed to Suicide? Not Six," *Suicide and Life-Threatening Behavior* 49, no. 2 (April 2019): 529–34.

4. John Deheegher, "Suicide of a Service Member: How to Organize Support for the Bereaved Service Members in the Emotional Aftermath," in *Lowering Suicide Risk in Returning Troops: Wounds of War,* ed. Brenda K. Wiederhold, (Fairfax, VA: IOS Press, 2008), 149.

event. Despite its importance, little has been written about how to respond to the aftermath of suicide-related events. In fact, a RAND report about the Department of Defense identified the response to suicide-related events as an area in critical need of study.[5]

In an effort to address this gap, the Defense Suicide Prevention Office published a Postvention Toolkit in 2019. The Toolkit details postvention procedures, roles, and responsibilities and includes checklists of immediate actions for unit leaders, chaplains, behavioral health providers, and other key players (for example, military investigators and casualty assistance officers) involved in managing a suicide death.[6] The Toolkit, however, does not address situations involving nonlethal suicide-related events nor does it provide nuances around managing suicide-related events and how these decisions operate in a real-world context. Leaders have much to consider in the aftermath of a suicide-related event, including their own emotional responses, and may feel alone in navigating this process. The present article expands upon the Postvention Toolkit by addressing these remaining gaps.

Building on a previous effort to study postvention practices during deployment, we have summarized leader decision making following a suicide-related event in garrison.[7] The current garrison-focused study, funded by the Military Operational Medicine Research Program and coordinated with the Defense Suicide Prevention Office, conducted 16 semi-structured interviews with five leaders, six chaplains, and five behavioral health providers, each of whom had responded to a garrison suicide-related event in the past five years. The study was approved by the Institutional Review Board of the Walter Reed Army Institute of Research, and participants provided informed consent. Leaders included Army officers with nine to 24 years of military service who served as company, battalion, and brigade commanders during these events. Chaplains included Army officers with 11 to 30 years of military service who served at the battalion and brigade levels and the state (National Guard) level. Behavioral health providers included social workers and clinical psychologists comprised of Army officers with two to 17 years of military service. Officers in each

5. Rajeev Ramchand et al., "Suicide Postvention in the Department of Defense: Evidence, Policies and Procedures, and Perspectives of Loss Survivors," *Rand Health Quarterly* 5, no. 2 (2015).

6. Department of Defense (DoD) and Defense Suicide Prevention Office (DSPO), "Postvention Toolkit for a Military Suicide Loss" (Washington, DC: DoD, 2019), https://www.dspo.mil/Portals/113/Documents/PostventionToolkit.pdf.

7. Abby Adler et al., "A Qualitative Analysis of Strategies for Managing Suicide-Related Events during Deployment from the Perspective of Army Behavioral Health Providers, Chaplains, and Leaders," *Military Psychology* 30, no. 2 (April 2018): 87–97.

category ranged in rank from captain to colonel, and there was one Army civilian behavioral health provider.

This paper reports on results from a thematic analysis of these interviews, provides brief case studies, and highlights lessons learned. Quotes were edited for clarity and to preserve anonymity. By leveraging the experience of leaders, chaplains, and behavioral health providers, we aim to offer a real-world perspective on navigating the challenges of suicide postvention. Themes are not presented in any particular order. Our intent is for this information to better equip leaders to respond to suicide-related events and mitigate the potentially negative impact on themselves, their units, and the wider community.

Confronting Personal Emotions about Suicide

The first theme that emerged from the interviews was how leaders described the aftermath of the suicide-related event in terms of their own emotional experience. Leaders, chaplains, and behavioral health providers who participated in the interviews experienced a range of emotions in response to suicide-related events. Many reported initial shock and disbelief, particularly because many thought the affected soldiers were doing well. Interviewees also mentioned feeling disappointment that the affected soldier did not reach out for help and self-doubt as to whether there was something they could have done differently. Finally, some experienced anger and frustration with themselves, the affected soldier, and the unit for not foreseeing and preventing the suicide.

Interviewees recognized the importance of being aware of their emotions and identifying ways to manage them. Some reported that taking leave from work provided a tactical pause to refocus on the tasks at hand. For others, the experience of a unit member's death by suicide led them to realize certain behaviors such as turning to alcohol were less productive, whereas other coping strategies such as connecting with family for support or engaging in recreational activities were more productive. As one leader mentioned: "I turned to that six-pack of beer, and did that very heavily, which was not helpful. I soon realized that talking with professionals and having open conversations with my wife about why I'm feeling that way, and taking breaks to do things I love, like travelling, hunting, and fishing, was what I needed most."

Leaders reported that suicide-related events negatively impacted their lives at home. One leader mentioned his high level of stress in response to the event made time with his wife and child more stressful than at any

other time in his career. Another leader expressed a similar experience of stress but discussed how they found it helpful to take the long way back from work or go for a run before returning home to readjust to family life after a stressful day.

General consensus emerged among respondents that the process of handling difficult personal emotions and learning about the issue of suicide offered an opportunity to develop as a leader. For example, one respondent reported that learning about suicide was professionally enlightening and helped him perform more effectively. Another leader reflected: "If you disregard the issue of suicide and say, 'that can't happen to me,' you risk losing credibility as a leader. These experiences have helped my personal growth and allowed me to evaluate my own priorities and move through life with purpose. Seeing through a different lens helped suspend my assumptions and embrace the reality of suicide."

For others, personal discomfort with the topic of suicide and avoidance of candid discussions served as barriers to unit cohesion: "I stayed positive around those soldiers, but I was uncomfortable talking about the subject. I had to put that behind me and ask the hard questions, otherwise I was going to miss something and wouldn't be able to help them." As this leader noted, engaging in genuine conversations with soldiers who were grappling with suicide-related issues was more productive than putting on a positive facade or ignoring the suicide.

By recognizing rather than avoiding personal emotions in response to a suicide-related event, leaders appear better able to respond effectively. Additionally, leaders reported the utility of engaging in productive coping strategies such as connecting with family for support or partaking in enjoyable activities outside of work.

Managing Stress around Blame

Besides their own emotions, leaders may also have to manage blame-related stressors. Despite leader efforts to prevent suicides, many respondents felt leaders often shouldered the blame for suicide-related events provoked by circumstances outside of their control.[8] In one case, a soldier was using illicit drugs, receiving addiction treatment, and being chaptered out of the Army. The soldier met with a behavioral health specialist who cleared him as "low risk." A week after the meeting, the soldier fatally stabbed himself. The soldier's parent called his commander in the middle of the night,

8. Pak et al., "Suicide Postvention," 189, 195.

accusing him of killing their son. In another case, a soldier had received multiple DUIs, failed an Army Physical Fitness Test, and had marital issues. The soldier's parent blamed their son's leader for the suicide, which occurred shortly after the leader took command. In both cases, intense family grief and accusations exacerbated the emotional toll on leaders and made it more difficult for leaders to manage the aftermath effectively.

In addition to stress from grieving family members, leaders faced stress related to the completion of procedural requirements such as 15-6 investigations and the Department of Defense Suicide Event Report. Furthermore, leaders reported being confused about what actions to take in response to the suicide-related event. They indicated the investigations following a suicide appeared bureaucratic, burdensome, and focused on finding a scapegoat for the suicide. Personnel responsible for completing these procedural requirements may not be familiar with the principles of postvention and are not expected to play a role in postvention activities. Nevertheless, leaders wished a team would help them proactively work toward the next steps in managing the event and preventing a recurrence.

Generally, investigations were described as centering on uncovering the cause of the suicide rather than providing postvention guidance. For example, one investigation focused on determining whether barriers to seeking behavioral health services could have contributed to the suicide. Nonetheless, respondents expressed concern that the investigation process appeared to emphasize blame. Respondents also reported the investigation process detracted from other priorities such as checking in with those who may have been affected by the event and providing emotional support to subordinate leaders.

Whether being blamed by family members or experiencing the strain of an investigation, leaders may find themselves juggling additional sources of stress during this difficult time. Furthermore, while those affected by a suicide may seek answers to why it occurred, it is not always possible to identify a root cause.

Caring for Individual Soldiers and Sustaining Unit Readiness

Emotional support was a key theme across interviews, and several leaders reflected on the challenge of striking a balance between individual and unit needs. One observed that when navigating suicide-related events "making sure [soldiers] get the help they need but also holding them accountable was a hard balance—one that I haven't completely figured out." Although unit readiness was a priority, several leaders felt it was important

to consider the needs of individual soldiers when setting training expectations following a suicide in their unit. Considering the nature and culture of the organization was regarded as helpful in striking this balance between empathy and discipline. For example, leaders discussed the need to set aside time to mourn, reflect, and understand and then to move forward as a unit to refocus on the mission. Explicitly acknowledging this balance helped send a message to the unit that people come first and that their leadership cares. Not all respondents, however, felt this balance was supported: "First Sergeant said this is not a way to get out of training. You signed the dotted line. If you are having issues, get help, but if not, put your best effort forth. This is tough love."

This balance between empathy and discipline is a challenge for leaders. Resuming training too soon after a suicidal event could be jarring. Responses indicated moving from the period of mourning to refocusing on training has to be carefully timed. Shifting training by a week and reengaging in unit tasks could help morale and maintain discipline. One leader feared if his unit remained too engrossed in a suicide-related event, rather than getting "on the beat" and moving, it could damage unit morale and lead to suicide contagion.[9] This leader emphasized moving forward: "We're not going to delay our field training next week—it's going to run its course. We'll honor the individual's service, but then we're going back out to train."

Leaders reported the health of an organization's climate and culture determined the effectiveness of the organization's response to a suicide-related event. One leader felt it was important to be a selfless leader, mentor, and peer: "If you're not visible, present, and compassionate, you're going to have problems in the organization." Leaders emphasized caring for their soldiers and ensuring everyone received the support needed. According to one commander, "Leaders don't want to be considered callous. Some might argue that if you weren't caring about the individual, then you were a cause of the suicide."

Leaders reported simple acts can go a long way toward showing soldiers that leadership cares about their well-being. One leader noted the importance of "letting your walls down, allowing your emotions to show, taking off your rank, and being human and compassionate." The same leader added,

9. For additional information on suicide contagion, see Pak et al., "Suicide Postvention"; and Robert J. Ursano et al., "Risk of Suicide Attempt among Soldiers in Army Units with a History of Suicide Attempts," *JAMA Psychiatry* 74, no. 9 (2017): 924–31.

"If a soldier is in quarters, go visit them. It's not just the care you show to that individual, it's the care you have for the organization."

In addition, senior leaders found an open-door policy helped boost unit morale, foster trust, and increase awareness of personal problems insolvable at junior levels of leadership. One leader noted: "When I first assumed command, morale was very low. My First Sergeant and I were the gatekeepers of all that was going on in the unit. After the suicide, soldiers came to me with marital problems and other issues they couldn't solve with subordinate leadership." Despite efforts to build unit morale and support, soldiers may not always experience this support. According to the observation of one chaplain, soldiers feel they are "not more important than the materiel we manage in our unit—a tank, a Humvee, or their M16."

The health of an organization's climate and culture begins with a leader's commitment to being visible to, open with, and compassionate toward soldiers. By striking a balance between empathy and discipline—and carefully timing unit tasks and training events in the aftermath of a suicide—leaders can both support the needs of individual soldiers and maintain unit morale.

Leveraging Communication Channels

Another prominent theme was the importance of empowering subordinate leaders to help soldiers struggling with work or personal problems. This empowerment is intended to alleviate subordinate leaders' concern that suicidal events occurred on their watch. Leaders emphasized the importance of subordinate leaders knowing their soldiers, tracking their soldiers' actions, and keenly observing circumstances that could negatively impact well-being.

Following one suicide-related event, a battalion commander set the expectation that the immediate level of leadership within each company and platoon would monitor its soldiers and mitigate potential stressors. Consequently, lines of communication improved, enabling soldiers to feel more comfortable with speaking up if something was bothering them. Similarly, another commander, following a suicide-related event, reported explicitly holding his subordinate leaders accountable for providing engaged leadership, which helped identify unit members in need of additional support. This commander also communicated directly with chaplains and behavioral health providers to identify unit members struggling to cope with the suicide-related event. In another interview, a leader noticed his mid-level NCOs were shouldering a great deal of stress looking out for

their junior enlisted soldiers, which prompted him to coach his E7s and E8s to mentor and support these mid-level NCOs.

As these examples demonstrate, leaders play a critical role in assessing soldier risk, mitigating that risk, and creating a network of support. To help leaders in this role, the Army has developed and evaluated tools to support leaders with monitoring suicide risk in their respective units. The Behavioral Health Readiness and Suicide Risk Reduction Review (R4) was designed to help unit leaders review unit members in terms of (1) risk factors (for example, suicide-related thoughts and behaviors), (2) behavioral health profiles, (3) loss (for example, death of a close family member, a breakup, injury, financial hardship, or career transition), (4) social and psychological isolation, and (5) high-risk comments (for example, statements indicating suicide is acceptable).[10] Additionally, R4 provides recommendations for leaders depending on their level of responsibility, with tailored versions for platoon and company leaders.[11] Although it is difficult to determine empirically if R4 is effective, there is potential benefit from R4 when it comes to strengthening leaders' assessment and management of risk.[12]

While the interviews were conducted prior to the release of the R4 tool, respondents emphasized the need for all levels of leadership to continue fostering open communication channels following the immediate aftermath of a suicide. Even after regular training resumes, leaders may need to continue providing targeted support. A behavioral health provider reflected on the importance of communication with the affected unit: "We determined the unit needs and talked to the guys in the affected unit to get a pulse of how

10. Justin M. Curley et al., "Development of the U.S. Army's Suicide Prevention Leadership Tool: The Behavioral Health Readiness and Suicide Risk Reduction Review (R4)," *Military Medicine* 185, no. 5-6 (2020): e668–77.

11. Curley et al., "R4," e673–76.

12. Justin M. Curley et al., "Suicide Behavior Results from the U.S. Army's Suicide Prevention Leadership Tool Study: The Behavioral Health Readiness and Suicide Risk Reduction Review (R4)," *Military Medicine* 00 (2022): 1–9.

they were feeling. And then [we] followed up with the unit periodically." A chaplain emphasized the need to follow up with soldiers long-term.

> Following a suicidal event, people are stunned, and then things appear to return to normal. Weeks later, many experience a shift in thoughts and emotions and a sense of unfinished business. It's important to give it some time because you will likely need to address behavioral health challenges later on. Follow-ups are an extremely important source of new information.

Leaders also reported that open communication with the chaplains assigned to their unit provided invaluable information following a suicide-related event. Although some leaders felt the rules around confidentiality might impede the identification of additional at-risk soldiers, other leaders reported that chaplains were able to check on potentially worrisome issues within units (for example, suicidal thoughts, marital problems, and social isolation) and help mitigate the risk of future suicide-related events.

One leader asked their chaplain to provide weekly anonymous statistics to the command on the overall health of the unit (for example, marital problems, and suicidal ideations). They believed reporting the number of suicidal ideations each month provided a useful way of highlighting the overall risk facing the unit. Thus, chaplains could communicate risk levels to leadership while maintaining confidentiality. As one chaplain noted: "Confidentiality in the Chaplain Corps allows us to approach individuals who seem to be struggling, and when they report feeling better, that's a win. If we didn't have that confidentiality, there would be even more stigma and hiding of issues."

Chaplains and behavioral health providers can support a leader's efforts in fostering open communication channels following a suicide. In addition, empowering subordinate leaders to monitor soldiers for potential behavioral health concerns can help leaders identify unit members in need of additional support. Army tools such as R4 can help monitor suicide risk by tailoring recommendations to leaders at different levels of responsibility.

Planning the Postvention Response

Respondents noted the importance of taking the risk of suicide seriously while acknowledging sometimes the nature of the risk is only identified after the leader is confronted with a suicide-related event in their own

unit. As one leader noted, his past experience with suicide attuned him to the topic.

> After going to a funeral of a soldier from my first command, it made me react faster the next time. In my second command, I was more reflective and responded quicker when I saw someone going down the road of suicidal thoughts and made them go see someone. I had a better sense of when someone was truly stressed and wasn't saying anything about it.

Besides taking the risk of suicide seriously, leaders also talked about the importance of developing a plan for accessing behavioral health resources, though such a plan should be in place prior to a suicide-related event. Pairing servicemembers with appropriate resources can be facilitated by adapting leader tools like the R4 for the postvention phase.[13]

A net of behavioral health resources following a suicide can help improve unit coordination, ensure soldiers receive adequate support, and provide a safe environment. For example, leaders reported that, following a suicide, behavioral health providers supporting unit members with information on the grieving process and survivor's guilt were helpful. One chaplain suggested the Warrior Ethos (for example, "never leave a fallen comrade") supported the commitment of unit members to escort fellow soldiers to get help from a chaplain or behavioral health professional. As one chaplain noted, whenever he met with a soldier who was having a difficult time in response to a suicide-related event, the chaplain would routinely ask a battle buddy to accompany them as part of an extended safety net. Respondents concurred when a soldier expresses suicidal ideation or intent the immediate response should be to assign a trusted peer or leader to escort that soldier to the emergency department or behavioral health clinic for an evaluation and remain with the soldier until discharge or admission to an inpatient treatment facility. Consistent with the Army ACE (Ask, Care, and Escort) Suicide Intervention model, leaders described the need to ensure their subordinate leaders and soldiers were familiar with procedures for referring to medical and behavioral health care.[14]

Respondents commented on the importance of counteracting the stigma of seeking professional help through positive messaging amongst leadership and through leading by example. Following a suicide in his unit, one leader worked with his subordinate leaders to generate positive messaging

13. Curley et al., "R4," e672–73.
14. Rajeev Ramchand et al., "The War Within: Preventing Suicide in the US Military," *Rand Health Quarterly* 1 (Spring 2011): 128.

across the chain of command to normalize help-seeking behavior as an act of strength and courage rather than a sign of weakness and to emphasize sustaining physical and mental wellness. As this leader observed: "We have physical rehab for knees and backs that are broken, but when your mind is broken, you have rehab for that too. . . . And if Sergeant Major goes there, it sets the example to the unit that it's okay to go to the clinic for support." In this context, "broken" refers to mental health problems from which soldiers can recover much like physical injuries.

One behavioral health provider commented: "When the commander asked us to be there, he needed to know that they could depend on us. After the suicide happened, the whole brigade rallied with resources." These behavioral health professionals offered formal and informal approaches such as one-on-one counseling or small group sessions to provide a forum for soldiers to discuss their feelings. Following the discussions, behavioral health providers remained behind for informal closed-door sessions and made themselves available at morning sick call to provide additional nonclinical support. As one provider stated: "We were there to help, not clinically, but instead we put on a different hat temporarily and made them feel more comfortable to speak freely." Behavioral health providers can put on different hats and offer formal clinical and informal nonclinical support.

For soldiers who might not feel comfortable seeking support from their unit leadership, chaplain, or behavioral health services, leaders reported the benefit of making their soldiers aware of alternative postvention resources such as Army Community Services, Military OneSource, and Military and Family Life Counselors (MFLCs). For example, the MFLC Program offers short-term, nonmedical counseling support for a number of issues such as relationships, crisis intervention, stress management, grief, and occupational issues.[15] Since sessions are not documented and are treated less formally than therapy, soldiers may feel more comfortable engaging MFLC services. As one chaplain noted, "Some soldiers are disenchanted with chaplains because they are religious in nature. Others will not go to behavioral health because the visits are annotated in their records. The third option makes up the trifecta. MFLCs are generally older, more experienced practitioners who work in civilian clothes."

Respondents also described how during the postvention phase they chose to coordinate suicide awareness and prevention training events that generated awareness of high-risk categories (for example, relationship problems, legal or financial difficulties, or substance misuse) and reinforced

15. Thomas E. Trail et al., "An Evaluation of U.S. Military Non-Medical Counseling Programs," *Rand Health Quarterly* 8, no. 2 (2018), https://www.rand.org/pubs/periodicals/health-quarterly/issues/v8/n2/06.html.

a supportive and caring culture to help mitigate the risk of future suicide-related events. The concern about mitigating future suicide-related events was a priority for leaders even as they were trying to manage the postvention phase.

Each of these leader responses—from taking future suicide risk seriously to building a net of resources, normalizing help-seeking behavior, offering a variety of behavioral health services, and coordinating suicide awareness and prevention training events—reflects the desire to reduce the risk of additional suicide-related events and to establish a culture that proactively supports the behavioral health of unit members.

Building a Supportive Climate to Reintegrate At-Risk Soldiers

During the interviews, leaders described taking a number of actions to build a safe and supportive climate to help reintegrate at-risk soldiers after an evaluation or hospitalization. Leaders mentioned the degree to which the affected soldier believed the unit genuinely cared influenced the effectiveness of unit support. For instance, leaders mentioned that encouraging their squad leaders to set aside their rank periodically to listen actively to the affected soldier could show the individual leadership cares. Leaders and chaplains also commented on the importance of reintegrating soldiers who appeared socially isolated by encouraging them to connect with specific unit members and engaging them in group activities such as basketball or watching a movie. Such activities helped foster a sense of unit connection and belongingness for at-risk soldiers.

For soldiers deemed high-risk in terms of behavioral health problems, unit commanders received helpful guidance from behavioral health providers regarding the soldier's profile (for example, duty limitations and recommended command actions). In an effort to facilitate decision making among behavioral health providers, the Army developed the Behavioral Health Readiness Evaluation and Decision-Making Instrument. This tool standardizes the behavioral health provider's understanding of policies and procedures and clarifies under what circumstances a soldier should be profiled based on regulations.[16]

Although interviewees did not mention the Decision-Making Instrument, respondents shared the following recommendations to foster a safe

16. Justin M. Curley et al., "Results of the Behavioral Health Readiness Evaluation and Decision-Making Instrument Study.,"*Military Medicine* 186, no. S1 (January/February 2021): S142–52.

environment, offer unit support, and strengthen camaraderie. These actions should be conducted based on consultation with the behavioral health provider (see table 1).

Table 1: Recommendation for unit support of at-risk soldiers after suicide-related events

Recommendation	Implementation Considerations
Restrict access to lethal means.[17]	Lethal means may include medications, personal firearms, or sharp objects.
	Request soldiers secure their weapon or ammunition voluntarily at another location such as a trusted friend's house or the unit arms room.
	Restrictions should be made in coordination with behavioral health providers for the duration the soldier is considered at-risk.
Engage in upstream prevention.[18]	Ensure the soldier has the support needed to manage stressors that contributed to the suicide-related events.
	Some potential stressors include financial issues, legal problems, and relationship problems.
Ensure consistent leadership involvement.	Ensure first line leaders (team or squad leader) periodically check in on the soldier.
	During check-ins, leaders should engage the soldier with empathy and active listening.
Engage social support and reintegrate soldiers to unit.[19]	Assign the soldier a battle buddy for social support.
	Encourage involvement in unit-led or soldier-led group activities.
	Discourage social isolation within the unit and foster a culture of inclusion.
Facilitate behavioral health appointments.[20]	Ensure the soldier is aware of appointments, and ensure leaders allow sufficient time for the soldier to attend them.
	Remove potential barriers to utilization of behavioral health or other support systems, such as transportation limitations or scheduling conflicts.

Determining which actions to take to support at-risk soldiers can be difficult. Leaders may find it helpful to assess risk factors in their unit by using the Leader Suicide Risk Assessment Tool. This tool assesses suicide risk factors through seven risk areas. These risk areas include legal and discipline problems, occupational problems, access to firearms,

17. "Lethal Means Safety for Military Service Members and Their Families," DSPO (website), n.d., https://www.dspo.mil/Tools/Download-Library/LethalMeansSafety/; and Craig J. Bryan, *Rethinking Suicide: Why Prevention Fails, and How We Can Do Better* (New York: Oxford University Press, 2021), 165–71.
18. Tim Hoyt et al., "Development of a Leader Tool for Assessing and Mitigating Suicide Risk Factors," *Military Medicine* 185, no. S1 (January/February 2020): S334–41.
19. Rajeev Ramchand et al., "War Within."
20. Hoyt et al., "Leader Tool," 336.

relationship problems, financial problems, substance misuse, and psychiatric hospitalization or suicide attempts. This tool also prescribes concrete mitigation responses.[21] By assessing risk factors, leaders can monitor their unit's behavioral health, foster a sense of unit connection, strengthen camaraderie, and take appropriate actions to build a safe and supportive climate. Collectively these actions can help leaders successfully reintegrate at-risk soldiers in their unit.

Honoring the Life of a Soldier, Not the Suicidal Act

Within the first 15 days of a suicide, it is customary for unit leaders to conduct a memorial service.[22] There was general agreement across the interviews that the memorial service was one of the most difficult and potentially contentious parts of postvention. Several leaders were concerned a formal service would encourage their soldiers to perceive the suicide as an honorable act rather than a tragedy. Many leaders and chaplains expressed reservations about holding the same type of memorial event for a soldier who died by suicide as they would for a soldier who died during combat or training.

Rituals can play an integral role in providing closure for unit members and family grappling with a significant loss. Respondents agreed that if planned carefully to recognize the life and the service of the soldier rather than honor the suicidal act, then memorial services could help surviving unit members, family, and friends cope with grief. A behavioral health provider remarked, "There's always a service member who needs that closure—it's more for us and less for the service member who [died by] . . . suicide. It's helpful for the provider who offered the services to deal with grief and find closure. And it's a way to honor them."

Memorial services may also help demystify suicide and discourage future suicidal events. One Army leader reported, "We do a memorial to honor their service, not the decision they made. I want every leader to see that this was a tragic end state. It really crushed people. It's how you approach

21. Hoyt et al., "Leader Tool," 335–40.
22. DoD and DSPO, *Postvention Toolkit*, 27.

suicide and educate people at memorial services. I did not have any suicides in the brigade after this."

One leader modified the ceremony to emphasize that suicide was wrong and should not be "rewarded," in order to discourage future suicides. This leader said:

> [The Army conducts] . . . memorial ceremonies like a soldier is a hero, with the boot and rifle. We salute him like he was killed in action. Following back-to-back suicides, I worked with my chaplain on his ceremony speech. I gave a coin to his son as a token of his father's service. But by following other traditions of memorial etiquette to this soldier who [died by] . . . suicide we are covering up the issue. . . . My chain of command was very nervous when I wanted to change the ceremony. I didn't want to treat him like a hero killed by enemy fire. I didn't change everything I wanted. They still fired the volleys. The chaplain said we were grateful for his service.

Several respondents shared the sentiment that, though there may be a tendency to cast blame, prudence should be exercised in what is said at the service. Unit members can respond with anger and frustration when they hear a commander speak disrespectfully about a fellow soldier who died by suicide.[23] Even so, leaders, chaplains, and behavioral health providers remarked that their perspectives about suicide and memorial services evolved over time. A chaplain reflected on his shift in thinking regarding these issues: "Thinking about it, I have become more empathetic with people who have gone down that road alone and can understand the circumstances that brought them there. For memorial services, I went from 'no, we're good' and 'suck it up' to 'it's vitally important to honor these people.'"

In summary, leaders emphasized the importance of carefully planning memorial ceremonies to recognize the life and the service of the soldier rather than honor the suicidal act. In this way, memorial services can support surviving unit members, family, and friends in the coping process, provide a sense of closure for those affected by the suicide, and discourage future suicide-related events.

23. Pak et al., "Suicide Postvention," 189.

Integrating Lessons Learned

Based on the results from the study interviews, we offer several recommendations for units following suicide-related events (see table 2). First, suicide postvention may be best conducted through prioritizing preparation before the suicide-related event. Leaders, chaplains, and behavioral health providers should build strong relationships through frequent interactions. They should also prepare for worst-case scenarios by discussing how they would respond and work as a team.

In another form of preparation, leader training on suicide postvention could incorporate frank discussions on personal feelings and biases regarding suicide, including how much time is needed to mourn, when military training should resume, how to handle memorial services, how to manage attitudes about blame, and ways to engage in self-care. The goal of these discussions should be to emphasize the potential ripple effects of such events in a community, prepare leaders to be adaptive, attuned, and responsive to unit members, and foster a nonjudgmental culture in the aftermath. Leader professional development may offer a venue for the inclusion of these topics.

Additionally, the interviews revealed how suicide-related events can place a heavy burden on leaders. Division or brigade command groups should identify leaders with experience in managing such events to serve as mentors for other unit leaders in the context of postvention. By leveraging their experience, these mentors can help validate the challenges of postvention and provide practical guidance to leaders following a suicide in their unit, which may complement support from behavioral health providers and chaplains.

Table 2: Summary of recommendations based on findings

Recommendation	Goals
Maintain regular interactions between unit leaders, chaplains, and behavioral health providers.	Build stronger relationships prior to events.
	Clarify roles and expectations.
	Prepare coordinated responses for various scenarios.
Adapt leader trainings to incorporate frank discussions on personal feelings and biases related to suicide.	Promote awareness of the ripple effects of suicide in a community.
	Prepare leaders to be adaptive, attuned, and responsive to unit members.
	Foster a non-blame culture.
Identify division or brigade level leaders with prior experience in managing suicide-related events to serve as mentors for subordinate unit leaders.	Provide practical postvention guidance to subordinate leaders following a suicide in their unit.
	Support and validate junior leaders' challenges during postvention.
	Complement support from behavioral health providers and chaplains.

Conclusion

Many gray areas exist in the suicide postvention decision-making process, and leaders can choose from a number of strategies to mitigate potentially negative impact on themselves, their unit, and the wider community affected. The data reported here is not exhaustive—every leader has unique experiences and thoughts about how postvention can be better managed. The present study was designed to report on frank conversations with key community members: leaders, chaplains, and behavioral health providers. Together, their views aid in identifying themes that define aspects of postvention. We hope the results from this thematic analysis can help prioritize leader actions during the postvention process and support leader decision making following suicide-related events.

As the field of postvention evolves and our understanding of suicide changes, we may need a better approach to postvention. Craig J. Bryan contends we should rethink the prevailing notion of suicide as the result of mental illness accompanied by warning signs and instead acknowledge the dynamic and shifting risks associated with suicide and the degree to which it occurs when individuals do not appear to be struggling with mental health and there are few to no warning signs. In addition, suicide may be better understood as a consequence of decision-making processes influenced by environmental and social stressors (for example, legal concerns, financial pressures, or relationship

problems) rather than a result of individual characteristics or mental illness.[24] Such an approach broadens our view of suicide prevention and may be useful in shaping postvention practices focused on improving the social context rather than identifying other at-risk soldiers.

For leaders confronted with managing a suicide-related event, there is no simple checklist of actions to ensure optimal healing and eliminate risk among unit members. The data presented here illustrate some of the challenges leaders have faced in navigating the nuances of suicide postvention. Despite confronting a number of challenging emotions and circumstances, leaders reported various coping strategies to handle their emotions, myriad perspectives on leadership strategies to bolster the behavioral health of their unit, and significant shifts in their thinking about how to approach suicide risk. There are, however, other options to be considered, and there is an enterprise-wide team to help move the unit forward in a positive direction. Leaders emphasized the importance of empowering subordinate leaders to care for soldiers and of leveraging communication channels with the chain of command, chaplaincy, and behavioral health professionals to sense their unit's behavioral health, identify behavioral health problems before they become more serious, and help affected soldiers receive help in recovering. Finally, leaders grappled with the role of memorial services in honoring the soldier while acknowledging the reality of the loss to friends and family. The collective experiences of leaders, chaplains, and behavioral health providers offer a real-world perspective for navigating the challenges of suicide postvention on the wider community.

24. Bryan, *Rethinking Suicide*, 7, 32–34, and 47–50.

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