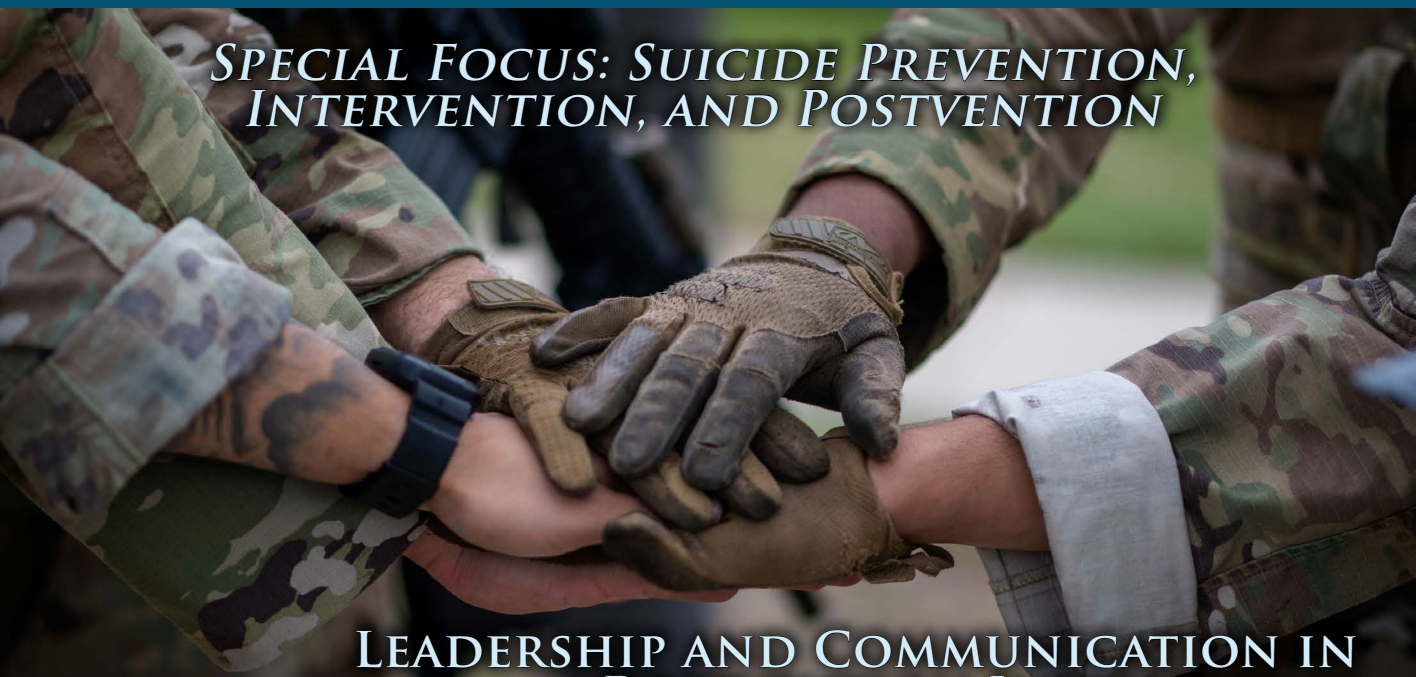
Department of the Air Force

# ASOR

## Air & Space Operations Review



### Special Focus: Suicide Prevention, Intervention, and Postvention

Leadership and Communication in Postvention Intelligence

Redefining Suicide Prevention in the Military

Suicide Postvention for Mental Health Professionals

The Meaningful Connection Pathway Model

Resilience Expectations

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DEPARTMENT OF THE AIR FORCE

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## AIR & SPACE OPERATIONS REVIEW



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# Air & Space Operations Review

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## FROM THE EDITOR

Dear Reader,

It is with great solemnity that we present this spring special focus issue of *Air & Space Operations Review* (*ASOR*), dedicated to a topic that affects not only the Department of the Air Force and the Department of Defense but also society as a whole.

For decades, the prevalence of suicide has weighed heavily on our communities. For service members, military service introduces additional layers of complexity to the demands of everyday life. Suicide has claimed more Airmen, Guardians, Soldiers, Sailors, and Marines than actual combat or combat training. Addressing this crisis requires more than fulfilling annual training requirements or checking a box—it demands meaningful engagement and proactive solutions. Our hope is that this issue of *ASOR* provides frontline supervisors, mentors, friends, coworkers, and healthcare professionals with valuable insights and tools to help fight the scourge of suicide within our ranks.

The issue begins with the **Suicide Prevention and Postvention** forum. John Hinck, Steven Davis, Alexandra Hinck, and Mary Bartlett lead the forum by exploring how Air Force leaders can foster meaningful conversations about suicide postvention. They offer effective ways to support Airmen and Guardians following a suicide attempt or death.

We then turn to Robert Redziniak, Philip Stewart, and Lucia MacPherson, who argue that by addressing the underlying causes of suicidal behavior and implementing organizational changes, the department can establish more effective prevention programs. Elisha Pippin concludes the forum with her analysis of suicide postvention support for mental health professionals. She contends that while the Air Force acknowledges the importance of postvention in suicide prevention, additional resources must be made available to mental healthcare providers to reduce adverse outcomes and enhance force effectiveness.

In the **Spirituality and Resilience** forum, Charles Seligman introduces a framework that positions spirituality as a crucial meaning-making activity for warfighter readiness. Finally, Kimberly Dickman challenges conventional discussions of resilience, cautioning that unrealistic expectations of healing may inadvertently cause harm rather than foster true resilience.

While we have previously published individual articles on suicide prevention, this is the first time we have dedicated an entire issue to the subject. For this, we are grateful to have received much support from Chief Master Sergeant of the Air Force David Flosi and Lieutenant Colonel Christopher Button, the Department of the Air Force suicide prevention program manager. Team *ASOR* would also like to acknowledge the issue's guest editor, Mary Bartlett, for her instrumental role in bringing this issue to publication and for her unwavering dedication to our Airmen and Guardians. We also extend our sincere appreciation to the peer reviewers who volunteered their time and expertise, as well as to the authors and healthcare professionals whose work—often difficult and underappreciated—provides critical support to service members in times of desperate need.

Each service member represents an irreplaceable part of our collective mission to defend this nation. This is not a Hollywood production—there are no extras among us, and no one is expendable in our story. Military service, by its very nature, involves the application of

violence, but the psychological toll of suicide loss on service members, their families and friends, their unit, and the clinicians who care for them can be profound. It is Team *ASOR*'s sincere hope that the articles in this issue serve as a vital resource in the ongoing effort to support our Airmen, Guardians, and Joint Force teammates in their journey to mental well-being, so we remain the most combat ready and lethal military force in the world.

~ The Editor

## FOREWORD

Chief Master Sergeant of the Air Force
David A. Flosi

The United States is at a critical juncture. The era of Great Power Competition marks a new security environment, and we are no longer afforded the safety of operating in uncontested environments. Make no mistake—our competitors are formidable and want to see our nation fail. To win today and in the future, the United States must cultivate leaders who are mission-ready, flexible, and resilient.

The US military is made up of volunteers, and the defense of our nation is a task never taken lightly. The weight of defending the Constitution against all enemies is a heavy burden. We owe every service member a debt of gratitude for putting on the uniform each morning. They are the lifeblood of our forces. Without these individuals, we cannot meet and defeat peer threats in contested environments across the globe.

Sometimes the burdens a service member carries in support of their nation are invisible, and sometimes those invisible struggles lead to tragedy. The uncomfortable truth is suicide is real and impacts our forces. Any suicide is a tragedy and terrible loss.

For the Air Force, the mission of *fly, fight, and win . . . anytime, anywhere*, cannot happen without every Airmen. We as wingmen need to do everything we can to prevent such losses. Yet the hard truth is sometimes the signs are missed, and when this happens, we must support our Air Force family members and those left behind. Every member of the Air Force needs to understand there are tools available when it comes to supporting each other, reducing suicide risk, and promoting healing and resilience.

Prevention, intervention, and postvention are heavily discussed throughout the articles in this special edition of *Air & Space Operations Review*. From the research presented, it is clear the authors leading the effort to reduce the number of suicides in the Air Force are knowledgeable and passionate about taking up the fight against suicide. It is up to us, however, to take what is discussed in these pages and find ways to use the recommendations.

Leveraging academic discussions and applying them to real-world situations takes critical thinking. Suicide prevention is a daunting task, but the Airmen of the world's premier air force cannot afford to let this monumental task take a back seat. We must use the data in these pages to make informed decisions and find new ways to develop solutions to implement prevention, intervention, and postvention strategies across all levels of the force.

This will not be easy. Not only will it take critical thinking, but it will also take Airmen digging deep into the topic of suicide. Surface-level thoughts and discussions will not help an Airman who is struggling silently. What will help them is being surrounded by wingmen who are ready to act and bring about change. Airmen who are willing to have open dialogue about hard, uncomfortable topics.

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*Chief Master Sergeant of the Air Force David Flosi is the 20th Chief Master Sergeant of the US Air Force.*

This special edition offers the perfect point from which to launch real conversations, and these conversations will have the potential to unleash new and innovative ideas. These ideas will help not only Airmen but also members of the Army, Navy, Marines, Space Force, and Coast Guard overcome the internal struggles they believe they must carry by themselves.

This effort demands great care, but once again, the Air Force will rise to the occasion. The US Air Force is the most trusted and capable air force in the world. Our Airmen prove this every day with their disciplined application of airpower . . . anytime, anywhere! ✈

# INTRODUCTION

Christopher J. Button

I am honored to introduce readers to this special issue of *Air & Space Operations Review*. The genesis for this issue was born out of the 2023 *Æther: A Journal of Strategic Airpower and Spacepower* special issue focused on moral injury.[1] The pages that follow represent the dedicated study of professionals who devote their life's work in the service of others to address suicide, this most perplexing of human problems.

The articles contained herein vary in perspective and focus, ranging from the role of organizational and leadership factors in suicide prevention to the potential deleterious effects of failing to validate individual emotions in current resilience approaches. Chaplain Charles Seligman, for example, illuminates the protective influence of spirituality, which gives rise to hope, purpose, and meaning—three ingredients critical to the preservation of life. Lieutenant Colonel Elisha Pippin proposes a postvention program to address the often-overlooked aspect of support for our caregivers, who balance caring for patients and grieving the loss of our Airmen. While these articles seem superficially disjointed, they—along with the others in this issue—collectively reflect the multifaceted nature of the problem we face. They are undoubtedly part of the inevitable solution.

As someone who reads every suicide death report and leads our suicide expert review panels, I offer a few observations and recommended actions. First, suicide is an incredibly complex problem. Most decedents faced similar stressors categorically, but the nature and confluence of the stressors within each situation were as unique as each service member.

Second, suicide is preventable. In my nearly 20 years of treating suicidal patients and in reviewing hundreds of records of those no longer with us, our Airmen most often chose to die over seemingly ordinary reasons, problems that were solvable if only they had accessed the right resource at the right time.

Third, time-based prevention works. The evidence is clear. If we collectively desire to rapidly reduce this unnecessary loss of life, everyone must join in placing time and distance between individuals vulnerable to experiencing emotional distress and ready access to lethal means. Safety is a part of our service's culture. Time-based prevention is simply about safety. Most suicidal people are ambivalent about dying. By safely storing firearms, medications, and other means of suicide, individuals experiencing distress are afforded time for their emotions to dissipate and for ambivalence to return, mitigating their engagement in life-ending action.

Fourth, postvention is critical to individual and collective recovery. Postvention is often fumbled due to concerns of perpetuating suicide risk. When done well, postvention facilitates healing, mitigates risk, memorializes the life of the decedent, and ensures mission readiness.

*Lieutenant Colonel Chris Button, USAF, PhD, serves as the Department of the Air Force suicide prevention program manager, Headquarters Air Force, Integrated Resilience.*

1. *Æther: A Journal of Strategic Airpower and Spacepower* 2, no. 3 (2023), https://www.airuniversity.af.edu/.

Finally, as a service, we own the preponderance of the reasons our most vulnerable fail to use our care and support systems. Although intended to mitigate risk to the mission, our policies are frequently cited by both our Airmen and the loved ones of those who passed away too soon as the primary reason individuals fail to seek help. Instead, most Airmen remain safely on the job while privately suffering from the very symptoms of distress that our policies were supposed to prevent from exposure to the mission.

This raises some questions: Are our policies working as originally intended? Do they unnecessarily expose the mission to undetected, unreported, and untreated risk? Do they unnecessarily prevent Airmen from getting the care they need, sometimes at the expense of their lives? My life's work has led me to conclude that we are naive to believe our Airmen will accept this personal risk. Therefore, we must review our policies to ensure Airmen are willing to receive help in the context of minimal fear and an accurate understanding of their personal risks, while also safeguarding the mission.

If I had one message to impart, it is that we can curb this trend in our ranks. I offer the following recommendations toward that end. First, do not dismiss everyday problems; without resolution they compound and may grow into suicidal crises. Address problems while they are singular, small, and ordinary. Support our Airmen in solving ordinary problems quickly and effectively.

Second, within your scope of influence, seek to enhance the quality of life for those around you. Individuals do not die by suicide when they lead lives worth living.

Third, recognize the systemic factors in your scope of responsibility that give rise to distress. Systemic factors are impossible for individuals to modify. When one's sense of self-determination is removed, hopelessness and helplessness set in. Left unchanged, suicide risk may soon follow.

Finally, in the wake of suicide loss, acknowledge others' grief. Suicide impacts each of us differently. As such, the path to recovery differs vastly. Support one another and do not fear talking about the loss, the impact, and most importantly, the memory of those who have gone from us too soon. Their lives mattered and they should be remembered.

One more thought—this special issue serves as a capstone to the dedicated service of guest editor Dr. Mary Bartlett, who resigned her position from Air University in pursuit of her life's purpose, advancing military suicide postvention. After 10 years of devoted pedagogy, she leaves a lasting impact on her students, the university, and the broader Air Force.

In closing, for each reader who has lost someone to suicide in the Department of the Air Force, I know I am unable to bring you any resolution to this tremendous loss. I promise you I wake each day in pursuit of an answer to prevent the next loss. In this, I hope you can find some solace in knowing that your pain and your loved one's loss are not meaningless, and that they will ultimately contribute to finding an impactful solution so others may not leave us before their time. ✈

# The Role of Leadership and Communication in Mental Health and Postvention Intelligence

John M. Hinck
Steven B. Davis
Alexandra Hinck
Mary Bartlett

US Air Force and mental healthcare community leaders, as members of a "team of teams," should address the military mental health challenge from the leadership and communication perspective that every person has the capacity to make a positive impact. Using a qualitative approach combining content, thematic, and historical analysis, this article demonstrates how the Air Force can help leaders have meaningful conversations about suicide postvention and offer effective ways to support Airmen and Guardians following a suicide attempt or death by suicide. By addressing the challenge and the role of leadership, this article demonstrates the importance of using supportive communication and advocates for a postvention intelligence framework and assessment to foster mental well-being and readiness within the Air Force.

Mental health continues to be a growing challenge across American society. Yet nowhere is this issue more acute than it is for service members, veterans, and their families, especially with the increasing demand for services and decreasing availability of providers. Often, those in and out of uniform who feel isolated and lonely fear shame for struggling with mental health. Without the proper social support from those they trust, feelings of isolation and stigma can be exacerbated.

Since 2019 the leading cause of death among Airmen and Guardians has been suicide, which exceeds deaths by accidents, natural causes, and combat combined.[1] Despite past efforts to combat death by suicide, many military members continue to take their lives, and others attempt to navigate a way to process their experiences and emotions.

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*Alexandra Hinck, PhD, is an assistant professor of communication studies at San Francisco State University.*

*Mary Bartlett, PhD, is an associate professor of leadership at the Leadership and Innovation Institute, Air War College, Air University.*

1. Defense Suicide Prevention Office (DSPO), *Annual Report on Suicide in the Military, Calendar Year 2023* (Department of Defense [DOD], Under Secretary for Defense and Personnel Readiness, 2024), https://www.dspo.mil/; and Marjan Ghahramanlou-Holloway et al., *2023 Total Force Department of the Air Force Standardized Suicide Fatality Analysis: Calendar Year 2020 Leadership Report* (Uniformed Services University of the Health Sciences, Suicide Care, Prevention, and Research Initiative, 2023), https://www.af.mil/.

This article serves as a method for military members and their families to process and support each other as they work through the complexity of mental health related to suicide. Military members and leadership should address the mental health challenge from a leadership and communication perspective, acknowledging that every person has the capacity to make a positive impact. For leaders of all titles and ranks across the military and other organizations, this article provides effective ways to understand and provide social support following a suicide attempt or death and to make a difference in the lives of others as a preventive measure.

A historical analysis of suicide, prevention, and postvention in the US military provides the context for understanding the evolution of perceptions concerning these issues and the move toward an emphasis on postvention—the response to a suicide attempt or death by suicide that promotes healing and seeks to alleviate negative impacts—as prevention. Furthermore, in addressing the challenge and the role of leadership, this article indicates the importance of using supportive communication and advocates for the implementation of the recently developed postvention intelligence framework and assessment (PIFA).

Although the Department of the Air Force (DAF) has made considerable progress in expanding its postvention efforts, until the development of the PIFA, there have been few guides for leaders to utilize as they provide support after a suicide attempt or death. This guide represents a step in the right direction, offering a mechanism to promote discussions to reduce the stigma of mental health and decrease the risk of contagion. Using the postvention intelligence framework assessment, individuals will learn how to be more aware of connections with individuals who are struggling with mental health and how to create these connections. Further, it can help individuals and leaders reflect on how their self, unit, and organization can support each other as they experience hardship. The authors believe that the PIFA method can reduce the stigma of mental health struggles within the military and encourage supportive communication within the unit and organization. In concert with supportive communication from leadership, such resources have profound implications for not only suicide prevention within the DAF but also overall well-being for all Airmen and Guardians.

## Societal and Military Struggles

The US surgeon general has announced that the country has an epidemic of loneliness.[2] Given that loneliness—along with disconnection, a sense of burdensomeness and of not feeling valued, a lack of purpose, and feelings of hopelessness—is a core component leading a person to die by suicide, there has been a concentrated effort among national organizations including the military to address these risk factors.[3] Society as a whole continues to wrestle with the issue of understanding what makes people die by suicide

2. Vivek H. Murthy, *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community* (US Public Health Service, 2023), https://www.hhs.gov/.

3. Thomas Joiner, *Myths About Suicide* (Harvard University Press, 2011).

and confronts the collective challenge on how to best educate and train others to appropriately respond to the actualities of suicide before, during, and after such events occur. The US military is also confronting this challenge as it faces a troubling increase in suicide losses among its members.

In 2023, the Department of Defense lost 523 service members and 146 family members to suicide and had 1,370 reported suicide attempts.[4] In the US military, many believe leaders are not adequately responding to the concerns, trends, and root causes of suicide. Military members serving on the frontlines of supervision continue to voice concern that leadership is not doing enough to combat suicide within its ranks. With mental health challenges and suicide rates continuing to rise, military leaders need ways to improve their knowledge and skills on both suicide prevention and postvention.[5]

Unlike within the community at large, leaders and decisionmakers within the Department of Defense have the unique authority and responsibility to be involved in and often engage in the lives of their subordinates where appropriate to improve quality of life and promote unit morale.[6] This includes offering support through challenging times and celebrating key events. Early intervention has long been the focus of suicide prevention efforts. The recent addition of postvention learning and activities has been found essential to mitigating the potential negative impacts following suicide loss or attempt—including subsequent suicide risk and other mental health issues.[7] Postvention focuses on a response to a suicide or suicide attempt through promoting healing, minimizing negative effects, and encouraging safe messaging.[8]

Furthermore, postvention also recognizes the complexity of suicide, particularly in a military setting. One report on Army suicide rates among armor brigade combat teams or tank brigades—the highest in the service—advocated for the identification of suicide as a highly complex problem with multiple risk factors rather than its classification as a mental health issue.[9] The report determined that high operational tempo—or the rate of military operations—coupled with a loss of cohesion among group members resulted in higher suicide rates in Army tank brigades. Given such considerations, the report emphasized that

4. DSPO, *Annual Report*.

5. David Nelson, "Air Force Policies Are Driving Airmen to Take Their Own Lives," *Task and Purpose*, 8 February 2022, https://taskandpurpose.com/; and James Schogol, "The Pentagon Is Changing How It Talks About Suicide," *Task and Purpose*, 20 October 2022, https://taskandpurpose.com/.

6. Air Force Instruction (AFI) 1-2, *Air Force Culture: Commander's Responsibilities* (Department of the Air Force, 8 May 2014).

7. See, for example, John R. Jordan, "Postvention Is Prevention—The Case for Suicide Postvention," *Death Studies* 41, no. 10 (2017), https://doi.org/; and DSPO, *Postvention Toolkit for a Military Suicide Loss* (DOD, 2020).

8. Suicide Prevention & Response Independent Review Committee (SPRIRC), *Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention & Response Independent Review Committee* (DOD, 4 January 2023), https://media.defense.gov/.

9. Nick Shifrin and Dan Sagalyn, "Study Finds Military Suicide Rates Highest Among Tank Brigades," 21 March 2024, *PBS News Hour*, transcript and audio, 8:34, https://www.pbs.org/.

there should be less focus on health-related solutions—such as access to treatment or crisis services—and more on understanding the complexity of risk factors, such as personal decision-making styles, the availability of lethal means, and financial uncertainty, among others.[10] Postvention aligns with this thinking, with an emphasis on the importance of establishing and fostering connections among others.

To mitigate the elevated risk to individuals, families, units, and communities that follow suicide deaths and suicidal behaviors, the Defense Department is proposing an investment in the development of postvention education and response to ensure the services are equipped and supported as they implement universal and targeted postvention education, as well as to ensure that suicide postvention response teams are trained, equipped, and activated throughout installations. These DOD postvention efforts are being collaboratively developed with the services as well as with expertise that exists in other large systems such as the healthcare field and academia, particularly around someone's lived experiences.[11] The Department of Defense is also standing up a lived experience working group to infuse the voices of those who have lost loved ones to suicide or have experienced suicidal behaviors into suicide prevention efforts, to include postvention. To augment these efforts already underway, improved assessment and intervention methods using empirically validated practices and improved curriculum for professional military education is being advanced.[12]

## History of Suicide, Prevention, and Postvention in the Military

An analysis of the history of perceptions toward suicide provides the context necessary to understand how changes in attitudes have shaped responses to suicide prevention and how and why postvention has emerged as a priority in suicide prevention. This in turn outlines the need for a clear way forward. The complexity of the perceptions toward suicide is situated in Western intellectual thought, beginning with ancient Greece and carried through the rise of Christianity in the medieval era through the expansion of insane asylums in the early modern era and up to the end of World War II. While suicide has been a recorded phenomenon as far back as written history and oral traditions extend, suicide as preventable without incarceration or institutionalization is a concept largely restricted to the twentieth century in Western civilization.[13]

For much of the Middle Ages in Christian Europe, suicide was seen as the work of the devil and regarded as a sin that was both immoral and illegal. As the feudal system declined and Christianity's authority eroded during the Enlightenment into the modern era, suicide began to be seen as a sign of insanity. Those with mental illness were hospitalized and/or

10. Shifrin and Sagalyn.

11. Christopher Button et al., "Development and Application of a Suicide Postvention Command Support Team to Assess Social-Ecological Factors Affecting Suicide Risk on Military Installations: Findings, Recommendations, and Lessons," presentation, American Association of Suicidology, Las Vegas, NV, 8 May 2024.

12. Alicia Matteson, personal communication with Mary Bartlett.

13. John R. Watt, *From Sin to Insanity: Suicide in Early Modern Europe* (Cornell University Press, 2004).

institutionalized in an attempt to prevent them from hurting themselves, but mental illness leading to suicide was not widely considered as treatable.[14] It was not until nineteenth-century positivism gave rise to psychology and psychiatry and the growth of these fields into the mid-twentieth century that suicide began to be seen as a symptom of mental illness that could be prevented through intervention, psychotherapy, and medication.

Yet while the stigma of threats to and thoughts surrounding suicide were beginning to dissipate in the United States, the military was often behind in its recognition and response to the issue. It was not until the 1950s that initiatives to prevent suicide in the US military began, and they have continued up to the present day. Major pivotal points in this trajectory include the shift in the 1990s from merely tracking suicides to an active agenda focused on prevention, the rise of centrally organized prevention measures in each branch of the armed forces in the 2000s, the shift toward suicide and mental health as a leadership imperative and responsibility rather than as purely the realm of specialists in the 2010s, and the rise of postvention in the last decade.

The first suicide prevention center in the United States was opened in Los Angeles in 1958 with funding from the US public health service. In 1966, the Center for Studies of Suicide Prevention—later the Suicide Research Unit—was established at the National Institute of Mental Health (NIMH) of the National Institutes of Health. In 1970, the NIMH expanded discussion about the status of suicide prevention, presented relevant findings about suicide rates, and identified future directions and priorities of the topic.

Yet it was not until the mid-1990s when suicide took off as a political and social agenda within the United States.[15] Those who lost someone to suicide, known as survivors of suicide, began to mobilize the development of a national strategy for suicide prevention. As of 1995, suicide prevention had been recognized as a public health responsibility rather than one confined within clinical settings due to the trend in increasing suicide rates. Between 2000 and 2010, the responsibility of suicide prevention shifted to mental health professionals within clinical settings. Such collective efforts generated national awareness, and suicide prevention is now recognized as a public health responsibility rather than an exclusively clinical matter.[16]

At the same time that survivors of suicide were gaining momentum, the organization of large-scale suicide prevention efforts began in the armed forces. In the 1990s the US military first introduced large-scale suicide prevention efforts. The DAF had been tracking suicide rates since the 1980s but still considered suicide treatment and prevention as residing only within the domain of mental health experts; it was not associated with the responsibilities

14. Michel Foucault, *History of Madness* (Routledge, 2006).

15. Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military* (RAND, 2011).

16. Jerome M. Adams, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention* (US Department of Health and Human Services [HHS], Office of the Surgeon General [OSG], 2021), https://www.hhs.gov/; and OSG and National Action Alliance for Suicide Prevention (Action Alliance), *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (HHS, 2012).

of leaders and therefore not tied to leadership education.[17] In response to increasing numbers in the mid-1990s, an integrated project team was convened in 1996 to address Air Force suicides, which led to the creation of the Air Force suicide prevention program.[18] That program shifted suicide prevention from a medical issue to a commander's issue, relevant to all areas of the Airman's life, and the Air Force developed a comprehensive approach to suicide prevention. This marked a shift from suicide prevention falling under the primary management and responsibility of mental health professionals to include all leaders regardless of training or profession.

Drawing from the public health tracking system, the suicide prevention program developed a separate secure, web-based suicide event surveillance system, which also increased patient confidentiality. The Air Force health force protection office used data from this system to produce monthly and annual reports as well as address queries from leadership. The newly established office had the ability to track suicides of Airmen assigned to National Guard and Reserve components who were not on active-duty status.

Air Force suicides decreased following implementation of its program. The impact and implications were documented in scholarly research literature, and the Air Force was recognized as having one of the top-10 suicide prevention programs in the United States.[19] The success of the program led to other military and civilian suicide prevention programs adopting some of the same core elements.[20] In 2015, the DAF was the first branch to formally develop a postvention curriculum and infuse tiered postvention training across its professional military education, setting another gold standard for all branches.

Still, in 2019, the Air Force experienced its highest number of losses to suicide, causing alarm among its most senior leaders. The challenge then became how to best educate, train, and develop its people to counter this trend. The Department of Defense as a whole sought how to train leaders to rebuild communities impacted by losses to suicide, which negatively impacted morale and mission.

With the publication of the 2023 *White House Strategy for Reducing Military and Veteran Suicide*, and the 2024 publication of the *National Strategy for Suicide Prevention and Federal Action Plan*, the Defense Suicide Prevention Office has been charged with revising suicide prevention training and developing the first-ever postvention strategic plan.[21]

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17. Mark Olfson et al., "National Trends in Suicide Attempts Among Adults in the United States," *JAMA Psychiatry* 74, no. 11 (2017); and Mary Bartlett et al., "The History, Current State, and Future of Suicide Postvention in the Armed Services," panel presentation, Society for Military History Annual Meeting, San Diego, CA, 25 March 2023.

18. Susan L. Clark-Sestak et al., *Strengthening the Contributions of the Defense Suicide Prevention Office to DOD's Suicide Prevention Efforts,* IDA Paper P-8248 (Institute for Defense Analyses, 2016).

19. DSPO, *Annual Report*; and SPRIRC, *Preventing Suicide*.

20. Ramchand et al., *Preventing Suicide*.

21. *Reducing Military and Veteran Suicide: Advancing a Comprehensive, Cross-Sector, Evidence-Informed Public Health Strategy* (The White House, February 2023), https://bidenwhitehouse.archives.gov/; OSG and Action Alliance, *2012 National Strategy*; and *2024 National Strategy for Suicide Prevention* (HHS, 2024).

With mental health challenges and suicide rates continuing to rise in both the public health and military sectors, the need for increased focus on developing knowledge and skills has also risen. Rather than concentrating on the causes or risk factors of suicide, efforts are now being made to understand the aftermath of a suicide attempt or loss to prevent future trauma.

## The Importance of Postvention as Prevention

Whereas early suicide prevention efforts focused on intervention, psychotherapy, or medication, it is now believed that effective postvention learning and activities are key to mitigating suicidal contagion—or "copycat" suicides—and subsequent suicide risk. Postvention focuses on responding to a suicide attempt or suicide death by helping people grieve, minimizing blame, and ensuring safe messaging.[22] Its goals are to promote healthy healing, reduce the risk of contagion, and link others at risk to resources.[23]

Leadership serves as a role model and guides the response and healing process.[24] Based on the argument that postvention is the best prevention, it is imperative that leaders are trained and equipped to address postvention issues to lead their people and organizations through a suicide loss and beyond.[25] While efforts to train leaders in postvention actions are being made, there is still no mechanism to evaluate if these efforts are efficacious. This gap led to the development of the postvention intelligence framework and assessment (fig. 1).[26] As research suggests, helping people understand their level of intelligence regarding postvention may help with mitigating suicidal risk and contagion.[27]

Historically in the Air Force, suicide postvention support to commanders was informally supplemented through professional consultation with external subject matter experts. These requests for consultation often emerged when multiple suicides occurred at a single location and when military commanders recognized the value of obtaining the opinions of experts. This informal precedent resulted in the establishment of a grassroots protocol relying on best practices to deliver support, consultation, and evidence-based recommendations to commanders.

Recently, the Air Force implemented a command-requested postvention site visit relying on this historic model to deliberately assess suicide risk and protective factors present on military bases and to deliver actionable recommendations to reduce future

22. SPRIRC, *Preventing Suicide*.

23. *From Grief to Growth: Healing After a Suicide Loss*, 2nd ed. (Tragedy Assistance Program for Survivors, 2024), https://www.taps.org/; and SPRIRC, *Preventing Suicide*.

24. DSPO, *Postvention Toolkit*.

25. Rafael Aguirre and Heather Slater, "Suicide Postvention as Suicide Prevention: Improvement and Expansion in the United States," *Death Studies* 34, no. 6 (2010), https://doi.org/; and Jordan, "Postvention."

26. Survivors of Suicide Loss Task Force, *Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines* (Action Alliance, 2015), https://sprc.org/; and Adams, *Surgeon General's Call to Action*.

27. Jordan, "Postvention."

suicide risk.[28] Each visit was strategically developed to elucidate socioecological variables present on the installation that bear upon the problem. The model, currently under consideration for development by both the the Defense Suicide Prevention Office and the DAF, provides for a collaborative approach to the issue.[29]

The protocol has initially identified the extent of the problems suicide decedents face, including the effects of suicide exposure, the different applications of postvention efforts for suicide attempts versus deaths, the unique grief process, the varied ways in which leadership responds to a death by suicide, and the means by which the climate is evaluated and outcomes alleviated.[30] Yet, more needs to be done from the perspective that regardless of rank, position, title, and time in service, every person, Airman, and Guardian can step into the role of leadership and influence the rising rates of suicide. While educators must impress upon the supervisory force that they are a formidable part of leading Airmen and Guardians through this crisis, these service members must also recognize that leadership extends beyond the unit or institution's senior ranking cohort and includes them as well. Understanding the role of leadership may be the next step in the evolution of suicide prevention in determining how to make a more positive difference.

## Role of Leadership

Enlisted noncommissioned officers are heavily involved in the lives of those they lead, but Air Force policy clearly mandates that commanders have the ultimate accountability for their authority and responsibility to engage in the lives of their subordinates, where appropriate, to improve quality of life and promote unit morale.[31] Unfortunately, news and commentary publications tend to feature negative sentiments and portrayals of Air Force leadership's role in responding to suicide.[32] Consequently, junior enlisted members may view leadership's suicide prevention efforts negatively and harbor the feeling that the Air Force is more concerned with its image than with actually addressing the suicide crisis.[33]

Perhaps echoing the sentiments of such Airmen and Guardians, over 60 percent of respondents in a 2020 study in the United States believed that something needed to be done about suicide, but they were unsure how this would be done, or they felt isolated and that others were not ready to assist those with suicide ideations. Two out of every three in the survey believed they did not have enough knowledge, yet eight out of ten were open

28. Air Force Director, Integrated Resilience, "Postvention User Guidebook," working paper (DAF, December 2024).

29. Peter Lubens and Thomas A. Bruckner, "A Review of Military Health Research Using a Social–Ecological Framework," *American Journal of Health Promotion* 32, no. 4 (2018).

30. Karl Andriessen et al., "Current Postvention Research and Priorities for the Future," *The Journal of Crisis Intervention and Suicide Prevention* 38, no. 3 (2017); and Neil J. Gutin, "Understanding What Makes Suicide Grief Unique Is Essential for Treating Surviving Loved Ones," *Current Psychiatry* 17, no. 8 (2018).

31. AFI 1-2.

32. See, for example, Nelson, "Policies."

33. Schogol, "Pentagon."

to learning more. Nearly 78 percent felt that more training, education, and access to care would help reduce suicide.[34]

This article was an initial response to the concerns from US military leaders of such reports that Airmen and Guardians feel isolated, ill-prepared, and ready to learn more, to address the challenges of suicide, particularly in postvention, through their leadership education and development programs.[35] Further, this research has received attention from mental health practitioners across disciplines, scholars, and others who want a way to understand and influence rising suicide rates in their communities and personal lives as well as how to help those grieving loss in the postvention stage.[36] A challenge in leader development for all branches of the military and in institutions of higher education and other organizations is how to accomplish those goals.

Too many organizations continue to wrestle with suicide, which repeatedly and seriously impacts mission readiness, school life, and the overall sanctity of life. The collective role of leadership—whether military or civilian—is to individually understand and combat the challenges of suicide ideations and deaths by suicide, connect with people, and influence positive outcomes. These steps begin with how to establish a supportive and healthy communication climate.

## Supportive Communication and Social Support from Leaders

Significant research suggests that social support can have a positive impact on mental health and can reduce suicidal attempts. Talking about suicide loss and sharing post suicide experiences with others in one's community can reduce individual risk, a sense of loneliness, and contagion as well as increase awareness and connection.[37] Yet few service members reach out to anyone for social support, refusing to disclose how suicide impacts their own mental health, psychological distress, and thoughts of suicide. This is partly out of the fear of stigmatization surrounding discussions of mental health and fitness.[38] That is, many are

34. Suicide Prevention Resource Center, American Foundation for Suicide Prevention, and Action Alliance, *Public Perception of Mental Health and Suicide Prevention Survey Results* (The Harris Poll, 2022); and Survivors Task Force, *Responding to Grief*.

35. Suicide Prevention Resource Center, American Foundation for Suicide Prevention, and Action Alliance; and Survivors Task Force.

36. Mary Bartlett et al., "Freedom from Stigma: Using the Postvention Intelligence Framework to Help People Talk About Awareness, Connection, and Action," workshop, National Communication Association's 109th Annual Convention, 16–20 November 2023, National Harbor, MD.

37. Michaela Gehrmann et al., "Evaluating the Outcomes for Bereaved People Supported by a Community-Based Suicide Bereavement Service," *Crisis* (2020), https://doi.org/; and Jordan, "Postvention."

38. Shane K. Jamieson, John Cerel, and Megan Maple, "Impacts of Exposure to Suicide of a Military Colleague from the Lived Experience of Veterans: Informing Postvention Responses from a Military Cultural Perspective," *Death Studies* 48, no. 7 (2024), https://doi.org/.

reluctant to share their struggles with mental health due to the negative perceptions associated with psychological problems within a military setting.[39]

Additionally, the aftermath of a service member's suicide loss may be accompanied with all of the complex trappings of blame, guilt, and trauma often experienced by suicide survivors, compounding the stigma.[40] Survivors grieving a suicide loss may struggle with "the societal perception that the act of suicide is a failure by the victim and the family to deal with some emotional issue," leading to an increased risk of mental health concerns and thoughts of suicide for themselves.[41] Furthermore, when individuals do communicate their psychological distress and seek support from someone, confidants often lack knowledge and comfort discussing the topic: "Friends, neighbors, and coworkers may naively struggle with how to be supportive, feel uncomfortable with what to say, or have a limited capacity to offer comfort." This becomes an additional barrier to providing effective support.[42] Therefore, the military is stuck in a complex cycle of grief, mental health struggles, stigma, and death by suicide.

Social support from leaders within military structures is a key factor for breaking down stigmatic barriers and increasing mental health within the military. By providing social support to Airmen and Guardians, leaders can address such stigma and also illustrate the importance of supportive communication in which ideas, feelings, and information are shared in a positive, respectful, and empathetic manner. Reducing such stigmatization can also be accomplished through the development and application of intentional communicative and supportive practices among leaders as well as peers and practitioners, which can help them become more comfortable with having a dialogue on mental health and suicide.

Safe messaging following a suicide attempt or death by suicide needs to come from the leaders within the organization in recovery.[43] As previously mentioned, this includes all Airmen and Guardians who may step into the roles of leaders and who have the capacity for ensuring widespread messages of hope occur. The most meaningful impact is accomplished when leaders convey their understanding of the death and its impact on the surviving unit

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39. Teresa M. Greene-Shortridge, Timothy W. Britt, and Craig A. Castro, "The Stigma of Mental Health Problems in the Military," *Military Medicine* 172, no. 2 (2007), https://doi.org/.

40. Jennifer Harrington-LaMorie et al., "Surviving Families of Military Suicide Loss: Exploring Postvention Peer Support," *Death Studies* 42, no. 3 (2018), https://doi.org/.

41. Christopher J. Bryan and Emily A. Heron, "Belonging Protects Against Post-Deployment Depression in Military Personnel," *Depression and Anxiety* 32, no. 5 (2015), https://doi.org/; John Cerel et al., "Suicide Exposure in the Population: Perceptions of Impact and Closeness," *Suicide and Life-Threatening Behavior* 47, no. 6 (2017), https://doi.org/; and John G. Cvinar, "Do Suicide Survivors Suffer Social Stigma: A Review of the Literature," *Perspectives in Psychiatric Care* 41, no. 1 (2005), https://doi.org/.

42. Harrington-LaMorie et al., "Surviving Families."

43. Jack Jordan and John McIntosh, eds., *Grief After Suicide: Understanding the Consequences and Caring for the Survivors* (Routledge, 2011).

members, not just for combat-related deaths, but all deaths.[44] There is a long-standing tendency for leaders not recognizing or understanding their own biases about suicide to negatively influence the environment and morale of those they are required to guide back to the expected and much needed pre-suicide operational status. It is this lack of understanding that even without ill intent can slow down this goal and lead others who may be vulnerable to a similar outcome. Messaging, in short, is impactful.

To that end, for both pre- and postvention, the Defense Suicide Prevention Office created a messaging guide to assist Air Force leaders in using nomenclature that is based on best practices and in accordance with national standards to protect survivors.[45] The *Leader's Suicide Prevention Safe Messaging Guide* offers the language needed to open communication channels among Airmen and Guardians and their leaders by not only destigmatizing but also demystifying suicide loss. While it is widely understood that many factors play into any one death by suicide, it is also understood that educating members of all ranks and services can positively impact leaders to help the healing process and ensure safe messaging for the prevention of suicide.[46]

Surviving family members of military suicide believe that reducing mental health stigma and obtaining military leadership support are two important steps to reducing suicidal actions.[47] Bereavement scholars have found that supportive communication strategies such as self-disclosure can significantly help US veterans to process grief and reduce feelings of perceived burdensomeness.[48] Outside of the US military, creating bereavement support groups have helped adults overcome feelings of guilt and process their grief more quickly. A recent study shows that support groups often validate emotions and increase a sense of belonging within the group.[49] What this means is that without feeling supported, individuals are less likely to feel like they belong and more likely to feel detached from key supportive fellows and have a stronger likelihood of suicidal ideation.[50] Therefore, supportive communication from peers and leaders may act as a protective factor against suicide ideation.

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44. Craig J. Bryan, *Rethinking Suicide: Why Prevention Fails, and How We Can Do Better* (Oxford University Press, 2022).

45. *Leader's Suicide Prevention Safe Messaging Guide* (DSPO, 2020), https://www.dspo.mil/.

46. Jordan, "Postvention"; and Jordan and McIntosh, eds., *Grief After Suicide*.

47. Jessica M. LaCroix et al., "Missed Opportunities for Military Suicide Prevention: Perspectives of Suicide Loss Survivors," *Military Behavioral Health* 6, no. 3 (2018), https://doi.org/.

48. Brook A. Ammerman et al., "The Role of Suicide Stigma in Self-Disclosure Among Civilian and Veteran Populations," *Psychiatry Research* 309 (2022), https://doi.org/.

49. Selena O'Connell et al., " 'That Feeling of Solidarity and Not Being Alone Is Incredibly, Incredibly Healing': A Qualitative Study of Participating in Suicide Bereavement Peer Support Groups," *Death Studies* 48, no. 2 (2024), https://doi.org/.

50. Yossi Levi-Belz and Daniela Aisenberg, "Interpersonal Predictors of Suicide Ideation and Complicated-Grief Trajectories Among Suicide Bereaved Individuals: A Four-Year Longitudinal Study," *Journal of Affective Disorders* 282 (2021), https://doi.org/.

Supportive communication can be reinforced by a tool such as the postvention intelligence framework and assessment, which can be useful to measure postvention growth and recovery. The PIFA is one promising way to better understand oneself and others' levels of awareness, connections, and influence around knowing, feeling, and what to do regarding suicide. The framework invites meaningful discussions for leaders to make an impactful difference.

## Postvention Intelligence Framework and Assessment

The PIFA offers one solution to discerning if the current postvention education efforts are useful and efficacious. The tool was developed following studies to determine how the Department of the Air Force could provide a way for leaders to be better educated in having meaningful conversations about suicide postvention. Data was collected from four different studies involving participants who ranged in age, experience, gender, and race, including training at the 2022 Air Force Chaplain's Career College, the 2022 Global Strike Command Leader's Course, and the Leader Development Course for academic years 2021 and 2022 at the Air War College.

The resulting multilevel analysis revealed six categories organized along three themes: 1) the need for a new, valuable framework; 2) the levels of informing (self, team, organization); and 3) the periods of time (awareness/past, connecting/present, influencing/future). Together, these three levels of informing and three periods of time constitute the parameters of the PIFA, which provides a way to better understand, assess, and take action to improve postvention intelligence (PI) for individuals, teams, and organizations. Postvention intelligence, similar to emotional intelligence, can be defined as the awareness and understanding of measures following a suicide loss or attempt.

The PIFA (fig. 1) is used as a framework to increase awareness of the resources, history, and challenges surrounding suicide loss (awareness circle), to foster stronger connections with others (connection circle), and to open pathways that influence positive outcomes of informed, connected care (action circle) at the self, team, and organizational levels. Postvention is addressed as a means for prevention, and the PIFA is designed to foster valuable conversation that bridges personal experiences, suicide and mental health literature, and cultural elements of someone's situation. The assessment is comprised of 20 questions that are answered on a scale of 1 to 5 that yields an overall PI score out of 100; six smaller scores out of 30 for awareness, connection, action, self, team, and organization; and some guiding questions to discuss results.

This research and resulting instrument provide a holistic framework for a person, team, and organization to understand their PI score in relation to levels of operation (self, team, organization) and circles of influence (awareness, connection, action) and to thus improve one's PI score. It provides a relevant, easy-to-use, empirically developed assessment that measures PI, offering an empirical understanding of where to focus efforts on prevention and from where the challenges have occurred in someone's life (past, present, future). The tool also provides recommendations on how to improve one's PI score as they relate to

each of the nine areas in the assessment. Furthermore, it supports and connects learning to the efforts on suicide prevention and postvention initiatives, on ethics, and empathy, all of which are advocated by the Air Force.

| | **Awareness** of resources, history, and challenges | **Connection** in the present | **Influence** for informed connected care |
|---|---|---|---|
| | *Past-focused* | *Present-focused* | *Future-focused* |
| **Self** Level | Q3. I am aware of the mental health (MH)/ postvention resources available for me. | Q5. I find it a challenge to connect with myself & know that I am worthy of life. | Q7. I have no specific future plans to strengthen my usefulness/wellness. |
| | Q4. I know my own drawbacks and shortcomings regarding MH and postvention. | Q6. I have strong connections with others who are a part of my "social fabric" or social circle. | Q8. I know exactly what to do and where to go for situations involving a suicide or MH crisis. |
| | | | |
| **Team** Level | Q9. I am aware of my family/friends' challenges with MH. | Q11. I feel I can reach out or have reached out to others for help with my MH or own wellness. | Q13. I feel I can be counted on to help others dealing with MH challenges. |
| | Q10. I know the right language to talk about suicide/postvention with others. | Q12. Others have not reached out to me for help with their MH/wellness. | Q14. I have never been counted on by others regarding their MH. |
| | | | |
| **Organization** Level | Q15. I am aware of the MH/suicide history of my current unit/organization. | Q17. My unit positively supports and provides resources to strengthen my MH and wellness. | Q19. My organization can count on me to provide advice and assistance in the event of a MH issue or crisis. |
| | Q16. My organization has conducted meaningful training and education regarding mental health (e.g., suicide awareness, postvention, etc.) | Q18. I feel connected in meaningful ways to the people in my organization *and* they feel connected to me. | Q20. There is no one in my unit I could name for whom I could make a difference with or in their MH or wellness. |

**Figure 1. Postvention intelligence and assessment framework**

Building a healthy communication inquiry can be useful, and the PIFA addresses two challenges in many communities. First, the PIFA advances health communication research that focuses on designing and implementing strategic evidence-based communication programs, policies, practices, and tools that use multiple media and adaptive messages, to disseminate meaningful, motivating, and actionable health information to healthcare consumers, providers, and policymakers.[51] Second, the PIFA supports health information

51. Bartlett et al., "Freedom."

practices within and between nations to build both local and global collaborations that address serious health risks, including problems with misinformation and resistance to adopt important health promotion practices demonstrated to be effective.[52]

Of the participants who volunteered to take the assessment and who employed the communication practices, 96 percent reported that the PIFA was an extremely useful tool to have meaningful discussions about suicide, believed they could use it at their own workplace and personal lives, and felt that it improved their understanding of suicide and postvention.[53] The PIFA has currently gone through nine revisions based on feedback from content experts, survey methodologists, and volunteer participants.

The next steps for this research are to determine the level of fit for the questions under each of the six categories and to validate and revise the assessment. Adding ways to increase the scores in each of the six categories will help participants understand how to improve their overall PI score. Hence, this underlies and supports the need for stronger leadership and better supportive communication around suicide and mental health, particularly during postvention.

## Conclusion

Historically, leadership and mental health were not synonymously integrated; however, culture, military actions, and the psychological well-being of humans have had to evolve. The postvention and intelligence framework and assessment represents the results of extensive discussions about suicide, its implications for military members and their families, and the changing nature of prevention education.

In an effort to educate leaders in understanding postvention and postvention intelligence, a focus on effective postvention learning and activities is key to mitigating suicidal contagion and subsequent suicide risk as well as emphasizing the preservation of human life. The PIFA aims to increase leaders' understanding of how to best educate, train, and develop one's self and others to appropriately respond to the actualities of suicide before, during, and after such events occur.

Along with supportive communication methods and other postvention resources available to the US Air Force and mental healthcare community team of teams, the PIFA can be used to help create a more open atmosphere surrounding discussions of suicide loss that can dispel feelings of blame and stigmatization and encourage healing and understanding. By acknowledging postvention as prevention and the importance of supportive communication,

52. Gary L. Kreps, "Health What? My Long, Strange Trip Building Health Communication Inquiry," *Spectra*, 2 March 2023, https://www.natcom.org/.

53. Mary Bartlett, John Hinck, and Steven Davis, "Postvention Intelligence Framework Assessment: Evaluating Post-Suicide Mental Health for Self, Others, and Organizations," paper presented at the American Association of Suicidology Conference, Las Vegas, NV, 7–10 May 2024; Mary Bartlett et al., "Freedom"; and Kreps.

the team of teams can work together in developing stronger and better prepared leaders to guide those they supervise through precarious and sometimes painful experiences. ✈

# Redefining Suicide Prevention in the Military

## A Model for Human Flourishing

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Suicide is a critical public health issue, particularly within military communities, where unique stressors and challenges can exacerbate mental health problems. This article explores the integration of suicide prevention and human performance strategies, root cause analysis, and organizational development to create a comprehensive framework for addressing this complex problem. Although current Defense Department approaches focus on intervention and reaction, a modified approach of prevention and data-driven resource utilization has the potential to reduce the burden on service members without increasing manning or cost. By examining the underlying causes of suicidal behavior and implementing organizational changes, the department can establish more effective prevention programs, positioning established resources and service members for mission success in great power conflict.

Suicide is a leading cause of death worldwide, with profound social, economic, and psychological impacts.[1] The loss of life itself presents a significant economic cost, but there is also the immeasurable toll it takes on survivors.[2] Military communities are particularly vulnerable due to the unique stressors associated with military life, including the inherent challenges and dangers of military service.[3] Studies indicate that the

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1. "Suicide and Self-Harm Injury," Centers for Disease Control, National Center for Health Statistics, last reviewed 2 October 2024, https://www.cdc.gov/; and see Anna S. Mueller et al., "The Social Roots of Suicide: Theorizing How the External Social World Matters to Suicide and Suicide Prevention," *Frontiers in Psychology* 12, no. 62 (2021): 1569, https://doi.org/; and Jessica Green et al., "The Role of Psychological and Social Factors in the Relationship Between Attachment And Suicide: A Systematic Review," *Clinical Psychology and Psychotherapy* 27 (2020), https://doi.org/.

2. US Department of Transportation, "Department Guidance on Valuation of a Statistical Life in Economic Analysis," effective 7 May 2024, https://www.transportation.gov/.

3. See Michael D. Anestis and Craig J. Bryan, "Means and Capacity for Suicidal Behavior: A Comparison of the Ratio of Suicide Attempts and Deaths by Suicide in the US Military and General Population," *Journal of Affective Disorders* 148, no. 1 (2013), https://doi.org/; and Christina L. Patton, Matthew R. McNally, and

routine nature of deployments for an extended period of time pose an additional risk for military members.[4] What is encountered in connection with those deployments intensifies this impact.[5] Over the past 20 years, service members have returned from a deployment to a new normal—whether a positive or negative one—only to deploy again. They are thus subject to a constant state of instability in terms of having their basic human needs fulfilled.

Between 2011 and 2022, the Department of Defense identified 5,997 military members who died by suicide.[6] Traditional approaches to suicide prevention often focus on individual-level interventions, such as counseling and medication. These approaches come from prior cultural associations in which suicide and suicidal ideation have been stigmatized and are focused largely on factors which contribute to individual risk of suicide.[7] Yet these methods may not address the broader systemic issues that contribute to suicidal behavior.

This article proposes a comprehensive approach that integrates root cause analysis and organizational development to enhance suicide prevention efforts on military installations. Such an approach shifts efforts to prevention, rather than intervention, emphasizing human flourishing to prevent suicide rather than post-crisis reparative action. Early prevention and flourishing development ensure the well-being, mission capability, and sustainability of a force.

## Suicide Prevention in the Military

The US military has until relatively recently generally relied on preventative education measures to address suicide in the services. While there are indications that a shift in preventative efforts toward employing a primary preventative workforce may provide some measure of targeted prevention through focus on risk groups and necessary skill building,

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William J. Fremouw, "Military Versus Civilian Murder-Suicide," *Journal of Interpersonal Violence* 32, no. 17 (2017), https://doi.org/.

4. See Mark A. Reger et al., "Military Deployments and Suicide: A Critical Examination," *Perspectives on Psychological Science* 13, no. 6 (2018), https://doi.org/; and Mark A. Reger et al., "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, no. 6 (2015), https://doi.org/; Lauren M. Denneson et al., "Military Veterans' Experiences with Suicidal Ideation: Implications for Intervention and Prevention," *Suicide and Life-Threatening Behavior* 45, no. 4 (2015), https://doi.org/; and Yossi Levi-Belz, Ariel Ben-Yehuda, and Gadi Zerach, "Suicide Risk Among Combatants: The Longitudinal Contributions of Pre-Enlistment Characteristics, Pre-Deployment Personality Factors and Moral Injury," *Journal of Affective Disorders* 324 (2023), https://doi.org/.

5. A. J. Khan, B. J. Griffin, and S. Maguen, "A Review of Research on Moral Injury and Suicide Risk," *Current Treatment Options in Psychiatry* 10, no. 3 (2023), https://doi.org/; and AnnaBelle O. Bryan et al., "Moral Injury, Suicidal Ideation, and Suicide Attempts in a Military Sample," *Traumatology* 20, no. 3 (2014), https://doi.org/.

6. *Report to the Committees on Armed Services of the Senate and the House of Representative: Report on Incidence of Military Suicides by Military Job Code* (Office of the Under Secretary of Defense, Personnel and Readiness, July 2024), https://s3.amazonaws.com/.

7. See Thomas Joiner, *Why People Die By Suicide* (Harvard University Press, 2005).

this step is simply an extension of an intervention-based approach. Preventative education occurs within risk groups generally after identifying these risk groups through data analysis of incidents and trends. In such an instance, prevention depends on data around intervention necessity.

Such prevention thus takes place after identified events in the risk community and might better be defined as a global postvention effort. The response to death by suicide or suicide attempt in the populace in question drives its assessment as an at-risk community and informs ostensibly preventative efforts that are themselves a reaction. Although the crisis may not have been local, the focus of the efforts is in response to risk category post-events rather than as a comprehensive program to help military members flourish. This current systematic approach of prevention only centers on a small population of those identified as at-risk due to prevalence of intervention, attempt, or death by suicide, while other military subcommunities receive little to no preventative work.

Analysis of broader populations indicates that there is a need for preventative work beyond the risk group after-event recovery response. This can be demonstrated by an analysis of a 2018 case study. In 2018, an Air Force group-level organization at one installation experienced roughly 200 documented destructive behaviors from its 1,796 members, although those same members engaged with helping agencies only 2,005 times. This rate of assistance engagement was insufficient to alleviate the factors resulting in these behaviors.[8]

The unit's data revealed concerning trends in destructive behaviors and the significant resources required for support. A total of 38 Airmen reported thoughts of suicide, while Airmen knew of 34 others who had died by suicide. Additional challenges included a number of Airmen undergoing alcohol and drug abuse treatment and some others with mental health high-interest cases and family advocacy cases as well as other destructive behaviors. A total of 5,873 man-hours were spent reacting to these documented destructive behaviors from helping agencies, the legal office, command teams, and frontline supervisors. This included hundreds of one-on-one visits, workshops, and hours of counseling for various concerns.

These statistics highlight the severe emotional and behavioral issues within the unit and the substantial time and effort required from support agencies. This reactive strategy averaged approximately 30 man-hours lost for each situation that rose to the level of being a documented destructive behavior rather than preventing the behavior by early engagement in the first place. As a result, mission readiness of roughly 40 Air Force Specialty Codes was degraded.[9]

What this case study suggests is that some people suffered in silence due to the lack of manpower available to concentrate on preventative and proactive models of intervention at a lower level. Clinicians were compelled to focus more on reacting to concerns than on

8. 355th Mission Support Group Close Airman Support Team, "Close Airman Support - MSG Plan," PowerPoint slides, Davis-Monthan Air Force Base, 2018.

9. 355th Mission Support Group Close Airman Support Team.

helping individuals before issues arose, spending more time responding to crises rather than on building relationships and teaching self-care. In short, the bulk of time and effort was spent with a minority group that required intervention, meaning that the majority group was not tended to. The potential adverse outcome of this current model is that some of these individuals may eventually need intervention if faced with adversity they cannot overcome on their own.

A comprehensive reallocation and re-baselining of existing assets to promote the flourishing of all service members, rather than targeted interventions for risk groups, is a genuine prevention effort. It not only enables prevention across the force but also increases the service capacity to conduct great power conflict through ensuring increased mission readiness.

## Personal Adversity, Military Stressors, and Suicidal Ideation

An understanding of the unique challenges faced in military service is required to determine how and why suicide impacts service members. The main contributing factors to a military member's tread down the possible path of suicidal ideation can be categorized as psychological, social, environmental, organizational, leadership-related, and cultural in nature. Such factors must be considered in the context in which military members live and work; the member will thus encounter educational and preventative efforts in the areas of training and education, policy and procedure, and continuing effort.[10]

The developments that lead to suicidal ideation rarely involve a single event. More often, concurrent or subsequent events accumulate beyond a level of tolerable stress. While humans can increase function and productivity through optimum stress, exceeding these stressors can create distress.[11] Ultimately, this overwhelming effect becomes normalized in the military community, as the culture becomes one of achievement and performance, which carry a heavy weight for a military member's career through standards, performance reports, and awards.[12] The resulting normalization of high performance in the face of significant stressors creates an environment in which military members are expected to react to these stressors as if they remain in the span of optimal stress rather than distress. The general tendency for society at large to idolize the uniformed member as "the best" or as a hero only serves to exacerbate this. This environment generates a baseline of high-functioning, highly stressed individuals who are also subjected to varying types of additional stressors,

10. See Suicide Prevention & Response Independent Review Committee [SPRIRC], *Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention & Response Independent Review Committee* (DOD, 4 January 2023), https://media.defense.gov/.

11. See Olorunsola Henry Kofoworola and Ajibua Michael Alayode, "Strategies for Managing Stress for Optimal Job Performance," *International Journal of Psychological Studies* 4, no. 2 (2012), https://doi.org/.

12. Melissa Pack, "Headspace for USAF - Pilot Overview and Learnings," Highspot [platform], updated February 2023, https://view.highspot.com.

such as psychological responses to stress or substance or alcohol abuse, the latter which precedes about 30 percent of military suicides, according to one study.[13]

Additionally, there is likely an increased suicide risk based merely on environment. Although a 2024 report indicates that only 14 out of 49 military occupational codes with enough data to compare to the US civilian population had a higher rate of suicide, this comparison is likely misleading in that military members are a select population without a history of mental health diagnosis prior to joining, with both robust, no-cost mental and physical healthcare, and with economic security due to employment.[14] While no adjusted study has been performed against a civilian population that (1) would qualify for military service, (2) has robust healthcare—to include available medical and non-medical mental health support—and (3) has economic stability, the assumption is more than reasonable that such a population would show lower incidence of suicide and suicidal ideation.

Military culture is unique and frequently misunderstood; it represents a conglomeration of people from all socioeconomic backgrounds who may have never ordinarily shared the same space. Social relationships involve individuals from a variety of ages, experiences, and intentions and are often organized differently at just about every department, base, and unit, leading to unbalanced and often tempestuous social circles. Any instability in such social relationships can be exacerbated by hasty and irregular deployment and work schedules. These factors, normalized as a part of military life, can lead to change fatigue and can impact a service member's ability to evolve with mission needs.[15] Such optimal stress from environmental challenges can bring some members to the limit of their capacity, setting the stage for a single adverse event to cascade into suicidality.

Organizational factors such as unit culture and scheduling as well as members' experience of their direct leadership contribute to the steep increase in the number of scenarios where service members experience service-related trauma effects both in and out of combat. Such factors, along with the high demands and understaffing within the Defense Department, have resulted in the military up to this point placing the term *prevention* centimeters before *intervention*.[16] Such an approach suggests that the only

13. Jenni B. Teeters et al., "Substance Use Disorders in Military Veterans: Prevalence and Treatment Challenges," *Substance Abuse and Rehabilitation* 8 (2017), https://doi.org/.

14. *Report on Incidence of Military Suicides*.

15. See Blair Rhodes Ellis, "The Trauma in Organizational Change: Correlation Study of Change Fatigue and PTSD in the Workplace Regent University," (dissertation, Regent University, Virginia Beach, VA, 2019); and Michael Frone and Ann-Renee Blais, "Work Fatigue in a Non-Deployed Military Setting: Assessment, Prevalence, Predictors, and Outcomes," *International Journal of Environmental Research and Public Health* 16, no. 16 (2019), https://doi.org/.

16. See Michael K. Dalton et al., "Long-term Mental Health Trajectories of Injured Military Servicemembers: Comparing Combat to Noncombat Related Injuries," *Annals of Surgery* 277, no. 3 (2023), https://doi.org/; and Anna Gross-Harwood, Nadav Stern, and Danny Brom, "Exposure to Combat Experiences: PTSD, Somatization and Aggression Amongst Combat and Non-Combat Veterans," *International Journal of Psychology* 58, no. 5 (2023), https://doi.org/.

concern is members remain mission ready or "good enough for now"—much like what is suggested by just-in-time training rather than continuous readiness. Additionally, these factors create a perception that anything less than mission ready is detrimental to one's career and perpetuate the sense that help-seeking behaviors are appropriate only at the breaking point.[17]

Withdrawal and burnout represent two main adverse impacts of high operational tempo on an individual's well-being. Withdrawal, or the physical or psychological disengagement from one's organization, manifests in behaviors such as absenteeism, turnover, and tardiness but has also been marked in other behaviors such as "passive compliance, minimal effort on the job, and lack of creativity" as well as laziness.[18] Burnout, the "prolonged response to chronic emotional and interpersonal stressors on the job," is characterized by "the three dimensions of emotional exhaustion, cynicism, and inefficacy."[19] The two impacts are often intertwined: The general idea behind burnout is that people give more than they are capable of to a job, exhaust their mental and perhaps physical energy, and consequentially withdraw from the organization.

To change this mindset, it is necessary to make a shift in training, education, and leadership approach, which must be championed by leaders who can effect genuine change by developing preventative flourishing in the individuals who serve. This involves both an iterative and agile process in identifying barriers to help-seeking and prosocial behavior, as well as developing the comprehensive expansion of human flourishing.

Given these considerations, this article proposes a model based on organizational development and involving the application of behavioral science to improve both organizational effectiveness and member well-being. In the context of suicide prevention, organizational development can help create a supportive environment that promotes mental health and utilizes correlating data on well-being from beyond the current model to incorporate all human factors of how members are coping through their time in service. Organizational development is an ongoing process that requires continuous evaluation and improvement; organizations should regularly assess the effectiveness of their mental health initiatives and adjust as needed. This may involve collecting data on member well-being and monitoring the use of mental health services, all resources available—on and off post—and courses available on base. It may also involve seeking feedback from members.

This prevention model has been piloted at US Air Force installations but can be applied with necessary changes to other service branches. It differs from just-in-time intervention and invests in the expansion of the service member optimum stress bandwidth and the reduction of the impact of non-adverse-event stressors. As a result, not only does this

17. See Richard E. Heyman et al., "Systematic Review of the Military Career Impact of Mental Health Evaluation and Treatment," *Military Medicine* 187, no. 5–6 (2022), https://doi.org/.

18. Craig C. Pinder, *Work Motivation in Organization Behavior*, 2nd ed. (Psychology Press, 2008).

19. C. Maslach, W. B. Schaufeli, and M. P. Leiter, "Job Burnout," *Annual Review of Psychology* 52 (2001), https://doi.org/.

minimize adverse behaviors and outcomes, but also there is a deepening of capability for those engaging with preventative efforts, enabling both the wise utilization of limited resources in garrison as well as increased mission effectiveness through the expansion of optimal stress capabilities in individual service members.

## Human Flourishing Prevention Modeling: Operation MOJO

A case study of the application of this model, Operation MOJO, is presented here. Operation MOJO is an effort aiming to help service members find their "MOJO"—Met Obstacle, Jumped Over—by embedding a self-awareness and growth mindset focused on posttraumatic growth and connection into the unit's culture. In the current model of continuation, an individual faces adversity and engages in negative coping, and reactionary intervention occurs (fig. 1). The Operation MOJO suicide prevention model illustrates a structured pathway to reducing suicide risk by fostering resilience, connectedness, and self-care among Airmen (fig. 2).

The process begins with a trauma, incident, or issue, which then prompts the individual to engage in self-assessment and initiate self-care. Through self-care education and a growth mindset, Airmen build the foundation for resilience. As Airmen progress, they reach a decision point for resource intervention, emphasizing the importance of connectedness and leadership support. By facing the issue in a transformational manner, Airmen then work toward reducing physical and mental stress, ultimately leading to performance improvement. The next phase involves healing and recovery, where posttraumatic growth is encouraged through continuous self-assessment, connectedness, and self-care. This fosters a new positive normal, reinforcing overall well-being.

Operation MOJO integrates support from helping agencies, leadership, and organizational root cause analysis to create a total human performance support package, ultimately leading to reduced organizational suicide risk. As one clinician's guide on posttraumatic growth notes, "Regardless of the trauma or incident, patients felt similar feelings and clouded judgements."[20] This means that the body responds to stress in several ways well-known to the medical community. Such responses can be captured in a stress survey that can help members assess and understand what is going on with them mentally and in some cases physically in a nonconfrontational manner. Once a member recognizes their level of stress, they can more readily receive the care they need. Because such individuals respond to trauma similarly and face impaired decision-making, structured support and intervention are integral to prevent adverse outcomes.

20. Lawrence Calhoun and Richard G. Tedeschi, eds., *Facilitating Post-Traumatic Growth: A Clinician's Guide* (Routledge, 1999).

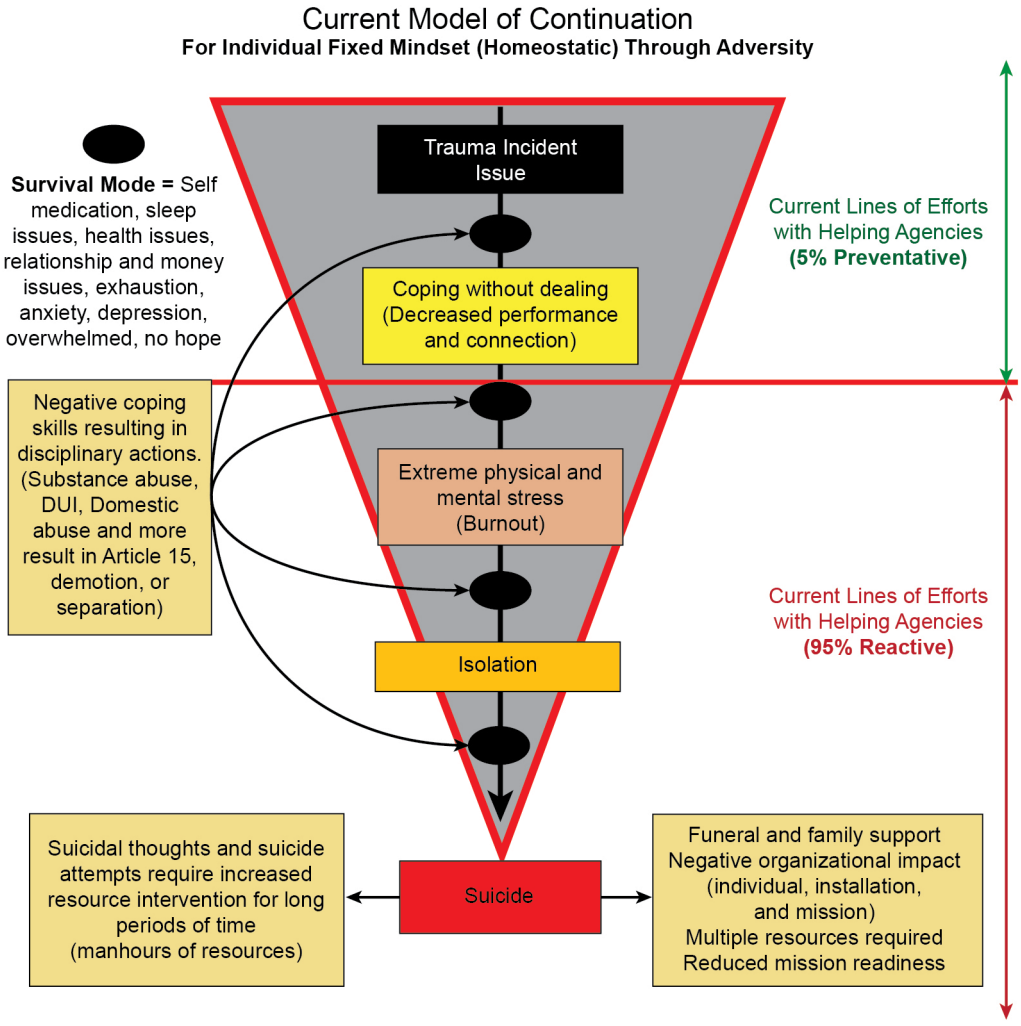


**Figure 1. Current pathway through adversity, for an individual fixed mindset**

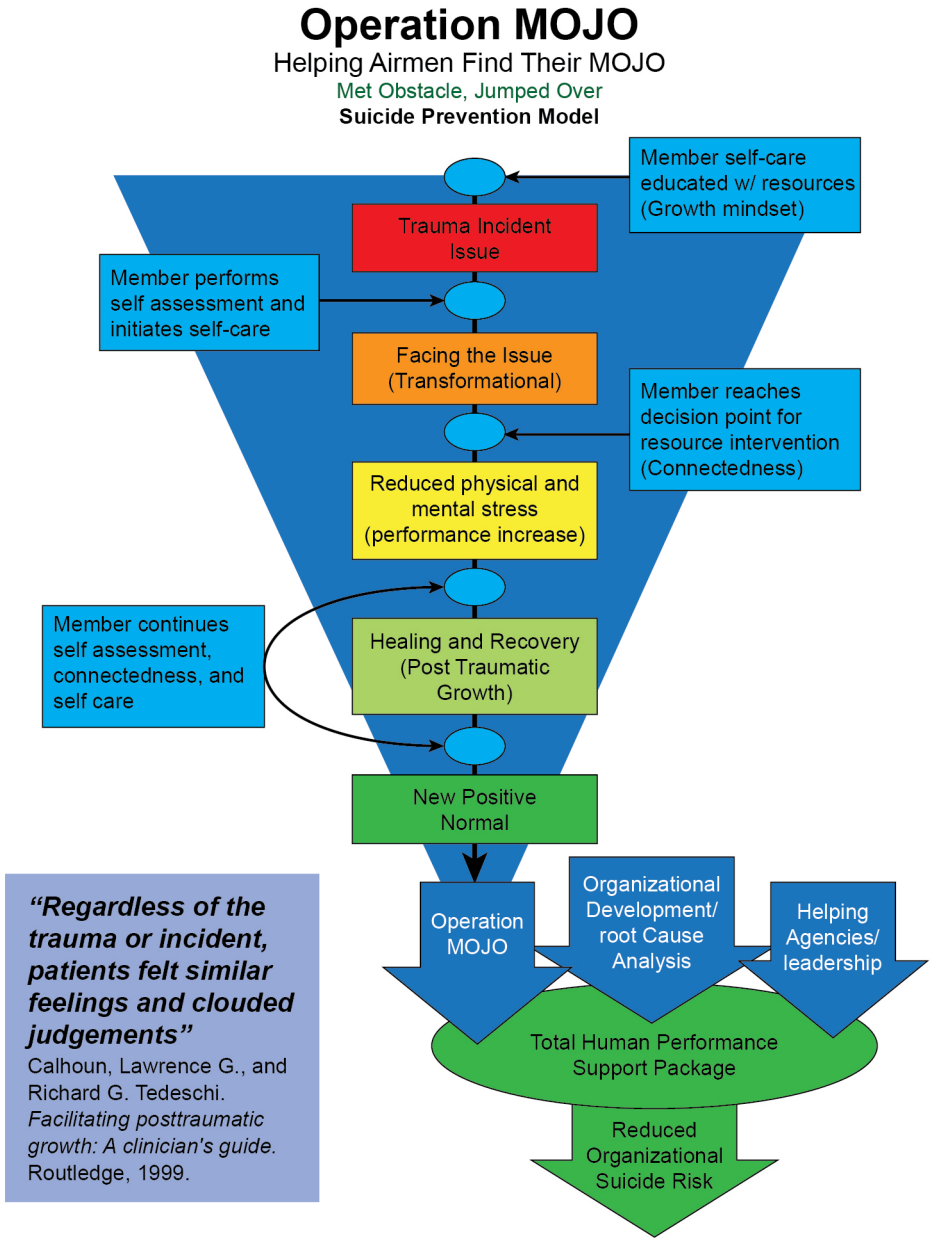


**Figure 2. Operation MOJO suicide prevention model**

Operation MOJO works as both an alternative and complementary approach to suicide prevention—alongside prevention frameworks currently employed by the Department of Defense—and provides a pathway for individuals to work through their hardships and become the best versions of themselves. Most importantly, it is an inclusive individual and

organizational toolkit designed for those suffering in silence, their family members, and anyone who wants to improve themselves. This approach not only enhances resilience but also enables individuals to thrive in all aspects of life. It empowers individual Airmen to have a growth mindset and to focus continually on self-care, providing returns for both the agency and growth of the individual. In doing so, Operation MOJO focuses on four areas along the pathway to well-being: a growth mindset, self-care, posttraumatic growth, and connectedness.

## *Growth Mindset*

A growth mindset allows individuals to face hardships or strive for self-improvement with an open mind, enabling them to learn and work through challenges, often emerging stronger.[21] It not only empowers people to take ownership of their lives but also builds self-confidence. In emphasizing such a mindset, Operation MOJO seeks to develop a perspective that sees stress as a motivator for personal growth rather than a negative force.

Moreover, these resources are already available within the military at no cost to the service member. Yet as root cause analysis reveals, there remains a significant disconnect between the individuals' need for help and their accessibility to this help. Many service members do not seek help when needed, for reasons including the stigma associated with mental health and work schedules. The Defense Department must remove barriers and embed resources within units for service members to access freely. In this way, responsibility of self-care falls on members who must learn to take care of themselves by using what is offered to them. Ultimately, even the best resources can only provide solid advice and tools for an individual to implement; the effort to change must come from the individual—what is commonly referred to as *grit*. With a growth mindset, service members will be more inclined to embrace the discomfort that comes with hardship, leading to improved human performance.

## *Self-Awareness*

The next step in Operation MOJO focuses on self-care, emphasizing what the individual has the most control over—the self. While every individual has their own concept of self-care, the most crucial aspect for implementation is self-awareness. Self-awareness involves being informed about health, including an understanding of one's mental and physical health status. Additionally, self-awareness encompasses life satisfaction and sense of organizational belonging, organizational citizenship, and perceived organizational and supervisory support. Self-awareness serves as a starting point for all future self-care activities, providing an honest look in the mirror and a deep dive into oneself through a comprehensive approach to fitness, across the eight pillars of the Chairman of the Joint Chiefs of Staff total force fitness

21. See, for example, Carol S. Dweck and Ellen L. Leggett, "A Social-Cognitive Approach to Motivation and Personality," *Psychological Review* 95, no. 2 (1988), https://psycnet.apa.org/; and Carol S. Dweck, *Mindset: The New Psychology of Success* (Random House, 2006).

framework—social, physical, environmental, spiritual, behavioral, psychological, nutritional, and medical and dental.[22]

## *Posttraumatic Growth*

The concept of posttraumatic growth (PTG) was first developed in 1995, with a more detailed model established recently.[23] PTG is defined as "positive psychological change experienced as a result of the struggle with trauma or highly challenging situations."[24] This phenomenon should be considered not as an alternative to negative psychological consequences but as a parallel process. PTG may feature positive changes in self-perception, interpersonal relationships, and philosophy of life, leading to increased self-awareness and self-confidence, a more open attitude toward others, a greater appreciation of life, and the discovery of new possibilities.[25]

The impact of such positive changes is explored in a definitive 37-year study on the longest-held prisoners of war in Vietnam—captive from the 1960s until the early 1970s. The study demonstrated how they overcame adversity while in captivity by applying the same optimistic mentality to challenges faced. The study noted that optimism is a protective factor for confronting trauma and argued that it can be increased in individuals through training.[26] This also underscores the importance of proper training and support reflected in the model.

An important aspect of focusing on posttraumatic growth is the ability to self-measure progress. The evaluative criteria for PTG in this model are as follows:

- Appreciation of life: A heightened sense of gratitude toward life
- Relationships with others: Improved personal relationships and increased pleasure derived from being around loved ones
- New possibilities in life: Embracing new opportunities, both personally and professionally

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22. See Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3405.01, *Chairman's Total Force Fitness Framework* (CJCS, 2011, current as of 13 September 2013), https://www.jcs.mil/; and Department of Defense Instruction (DODI) 1010.10, *Health Promotion and Disease Prevention* (DOD, 28 April 2014, incorporating change 3, effective 16 May 2022), https://www.esd.whs.mil/.

23. Richard G. Tedeschi and Lawrence G. Calhoun, *Trauma & Transformation: Growing in the Aftermath of Suffering* (SAGE Publications, 1995); and see Richard G. Tedeschi et al., *Posttraumatic Growth: Theory, Research, and Applications* (Routledge, 2018); and Adam Kadri, Frances Gracey, and Adrian Leddy, "What Factors are Associated with Posttraumatic Growth in Older Adults? A Systematic Review," *Clinical Gerontologist* 48, no. 1 (2025), https://doi.org/.

24. Richard G. Tedeschi and Lawrence G. Calhoun, "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," *Psychological Inquiry* 15, no. 1: 1, https://psycnet.apa.org/.

25. R. G. Tedeschi and L. G. Calhoun, "The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma," *Journal of Traumatic Stress* 9, no. 3 (1996), https://doi.org/.

26. Francine Segovia et al., "Optimism Predicts Resilience in Repatriated Prisoners of War: A 37-Year Longitudinal Study," *Journal of Traumatic Stress* 25, no. 3 (2012), https://doi.org/.

- Personal strength: Increased emotional strength and resilience
- Spiritual change: Greater spiritual connection

### *Connectedness*

Connectedness is a continuous improvement and offers an organizational development approach to suicide prevention. The model highlighted the need for connection not only on an individual basis but also as an organizational design structure to overcome obstacles in life. Through the countermeasures developed by the root cause analyses, engagement in some units were doubled. The findings of the root cause analyses only highlighted the need for a different approach to employing resources and education on necessary life skills that affect the readiness and performance of an individual and unit. Utilizing an organizational developmental approach to these life skills proved critical in ensuring that both Airmen and their families could be ready and resilient and could perform well under the toughest of circumstances.

## Application of Operation MOJO Framework

An intelligence unit at the National Air and Space Intel Center (NASIC), Wright-Patterson Air Force Base (AFB), Ohio, employed the Operation MOJO framework through three separate self-care (training) days in 2022 over a period of six months, aiming to provide personal and professional readiness support to its members utilizing the total force fitness framework. The events were organized in response to a 2021 occupational health assessment with the 711th Human Performance Wing—currently the only measure of an organization's whole health—which revealed that almost half of the organization's personnel were experiencing various risk indicators, such as psychological distress, emotional exhaustion, and sleep difficulties, among other health- and wellness-related data.[27] The assessment also noted key health behaviors among unit members, including a high level of physical activity. Members further identified the possible impacts on their duty status or clearance, the perceived stigma of seeking mental healthcare, and their work schedules as being among their top concerns regarding access to mental health care. The events also correlated with the unit's climate assessment and showed a cause and effect between pain points in the unit and the impact it was having on their health.

There were 150 personnel who attended these non-mandatory events in a sensitive compartment information facility (SCIF), utilizing agencies that supported both military and civilian personnel. A major highlight of the self-care day was that it featured all the helping agencies in one place. The main challenge was organizing access to and from the secured building for all military and civilian agencies and representatives.

27. 711th Human Performance Wing, *2021 Occupational Health Assessment Report* (National Air & Space Intelligence Center, 2021).

Over the course of the six months, participant engagement increased from less than 1 percent to 70 percent due to the consecutive engagements—that is, building of trust by the repeated presence of individuals representing helping agencies—and relationship building between leadership, resources, and employees. The framework focused on a growth mindset, self-care, and connectedness between resources and personnel, sparking future interactions and normalization of a new type of non-crisis driven interaction in a non-threatening environment.

A focus group, the health and wellness working group, was formed to analyze why personnel were not using the available helping agencies and leadership support when faced with adversity. Similar to events in the 2018 case study mentioned above, a continuous process improvement event centered on the health and wellness of the organization, which also included root cause analyses, countermeasures, and results. Artificial intelligence was used to correlate the climate assessment survey and comments and the operational health assessment, which was then utilized to assist in developing a training plan to address many of the issues highlighted. Results focused not only on individual health but also on organizational issues, including trust, communication, and leadership, offering insight into readiness and other important mission essential metrics for future research.

The root causes identified included lack of information, trust issues with supervisors or organizational leaders, perceived impact on career, self-perception, and stigma surrounding seeking help. Based on this analysis, several countermeasures were outlined to address these issues, including improving communication about the helping agencies, promoting a culture of self-care and excellence, and ensuring the availability of resources for military and civilian employees and family members. There was also a significant difference between resources for military members versus civilians, as civilians had substantially less resources available.

A notable countermeasure that had a major impact on overcoming the perceived obstacles to mental healthcare access was the implementation of the mental wellness application Headspace. A four-month trial that included over 2,500 users at both Wright-Patterson AFB, and Minot AFB, North Dakota, produced a 93 percent success rate for utilization and likeability as it was on demand and helped Airmen and families discretely through a multitude of scenarios.[28] The trial not only demonstrated the flexibility and effectiveness of the app between large and small bases, but it also proved how it could ease the burden on mental health teams, who had purchased Headspace to help cope with provider burnout and high turnover rates. The trial also expanded access to care for personnel and their families for common issues such as sleep, stress, family matters, and performance.[29] The results demonstrate how such a tool or other similar ones could benefit providers and mental healthcare workers as well as Airmen and their families. These results were presented to senior Air Force leaders with the capacity to consider and procure funding for the application across the wider Department of the Air Force.

28. Pack, "Headspace."
29. Pack.

The resources utilized were the Civilian Health Personnel Services, the Military Family Readiness Center, Military and Family Life Counseling, the Employee Assistance Program professional financial advisers, dedicated human performance resources, the Consortium for Health and Military Performance total force fitness model, and the assigned chaplain. The agencies held interactive courses on sleep hygiene, mindfulness, finances, communication, spiritual well-being, conflict resolution, posture, and more. There were several versions of the National Air and Space Intel Center self-care day, with countless course offerings available from agencies both on and off base. Sessions were free for members, civilians, and their families. For example, one such self-care day included the following sessions:

- Growth Mindset, Self-Care, Connectedness - The Blueprint[30]
- Getting Physically Active & Fueling a Healthy Lifestyle – Civilian Health Personnel Services (CHPS)
- Maintaining Lines of Communication with a Personal Finance & Relationship Building Focus – Military Family Readiness Center
- Military and Family Life Counselor and Personal Finance Coach
- Creative Ways to Engage Our Spirituality – Chaplain
- Resolving Workplace Conflict – Employee Assistance Program
- Getting a Good Night's Sleep – CHPS/Human Performance Wing
- Reframing Mindfulness – Integrated Resilience Office

Positive feedback from 150 personnel on the NASIC self-care day highlighted the relevance and usefulness of the information provided, as well as the desire for more such events in the future. The event emphasized the importance of the unit's efforts to set a strong foundation for its members, focusing on health, wellness, and retention; empowering them with necessary skills; and elevating their overall experience. The feedback thus indicates the value of making self-care resources accessible to everyone, not just supervisors.

Participants appreciated the diverse topics covered and the practical resources provided. Many found the event uplifting, emphasizing the importance of self-care in maintaining personal and professional well-being. Key takeaways included mindfulness techniques, financial awareness, the significance of sleep, and stress management strategies such as box breathing and sour candy for anxiety. Attendees expressed strong support for more events like this, suggesting larger venues and even an annual self-care day. Overall, the event was well received, with gratitude for the effort in organizing it.

Additionally, NASIC hosted three community fairs where hobbies and sports were showcased, allowing Airmen and families to sign up for groups like ultimate frisbee,

30. Secretary of the Air Force Public Affairs, "The Blueprint: Roadmap to Enlisted Force Development," US Air Force (website), 22 April 2022, https://www.af.mil/.

running, hiking, and 3D-printing clubs, while also providing opportunities to connect with the helping agencies. The fairs offered a neutral environment for participants to socialize and connect with whomever they chose. The increased agency presence in a SCIF also produced meet-and-greet opportunities for leadership teams, agencies, and workforce. Although as previously mentioned, there were a few challenges with getting some agencies into the secured space, ultimately the fairs helped to destigmatize mental healthcare resources by increasing trust among Airmen and the participating agencies, providing a psychologically safe and healthy work environment. Furthermore, continued repetition of these events created longer lasting relationships among unit members. This resulted in further collaboration between NASIC and the resources in several key events throughout the year, building an enduring relationship from the needs of the unit.

Ultimately, the application of the Operation MOJO framework at NASIC not only empowered personnel but also contributed to a healthier work environment, with continued engagement leading to sustained benefits for both individuals and the organization.

## Conclusion

Currently, there is no standard approach in the Air Force to measure an organization's whole health experience that allows for both the helping agencies and leadership teams to see real-time data and ensure the unit is supporting Airmen as needed. The 711th Human Performance Wing occupational health assessment is the first model approved to collect data toward that goal. Additionally, much of the data, regardless of the source, is not whole-health focused, proactively collected, shared, assessed, or acted on, all of which was highlighted to the Fortify the Force Initiative, the Air Force's combined effort between organizations and individuals to "advocate for total-force fitness, resource awareness and accessibility of care so that all Airmen, Guardians and family members can thrive."[31]

Although the Fortify the Force initiative involved several lines of effort, the embedded care team line of effort—including more than 20 variations of the current embedded care models—created competition, lacked collaboration, and prevented information from being shared amongst team members. There is no agreed-upon metric for prevention efforts for each embedded medical discipline, resulting in the lack of justification for their existence.[32] Further, cooperation between embedded care programs and helping agencies was minimal, largely because most providers were set on their respective program being the solution for a unit.[33] This created a major gap in capabilities and a loss of an opportunity to create a thriving whole health model of care for the unit as warfighters were dealing with a multitude of issues that were not specifically related to medical issues.

31. "Department of the Air Force (DAF) Fortify the Force," accessed 5 March 2025, https://www.aflcmc.af.mil/.

32. "LOE - Embedded Resources – FFIT: Official Lines of Effort" (DAF, 2022).

33. "LOE."

Although such Department of the Air Force suicide prevention initiatives emphasize the necessity of proactive work, most of the effort is put toward reactive methodology, limiting the access to care and guided or self-intervention at lower levels. Not only is growing from a reactionary model to a capabilities-based strategy holistically the more effective option for suicide prevention, but it also develops human flourishing and drives an agile force with greater capacities for mission execution.

This is where the framework of Operation MOJO would be most successful with a shift to the institutionalization of self-care while finding and removing barriers between organizations and helping agencies. If the current model is continued and the Air Force were to enter a near-peer conflict, then it is likely to fail as an institution because it lacks what is necessary for Airmen: an integral focus on whole health.

Suicide prevention is a complex and multifaceted issue that requires a comprehensive approach. By integrating root cause analysis and organizational development principles, the Air Force and the Department of Defense as a whole can develop more effective strategies to address the underlying causes of suicidal behavior —which are compounded issues—and create supportive environments. Whether through the proposed model or another similar one, prevention must move from just-in-time to the creation of genuine environments for flourishing in order to stem the tide of suicidal ideations and behaviors within the military.

This is particularly true in future constructs in which existing support resources are increasingly constrained in garrison. To simplify, a service member would not be sent to war without being properly trained on mission success. It is equally important to train them on life success, to deal with the well-known documented issues of returning home as well as other challenges specific to military life. Service members are only as good as they are trained for mission execution, and that applies to their training for life as well. Any high performing sports team has robust support resources to fall back on through a rigorous season filled with mental and physical challenges that reach beyond the field they play for both on and off season. The same should be true for the team of service members. ✈

# Suicide Postvention for Mental Health Professionals

## Addressing the Gap in Military Healthcare

Elisha Parkhill Pippin

Despite Department of the Air Force and broader Defense Department efforts to address suicide prevention in the service, the focus has been directed to military members with little attention to the healthcare professionals who care for them. As the demand for clinical mental health services rises, these professionals must receive the appropriate support to maintain their well-being and that of their patients—including postvention resources, which mitigate the impact and cumulative stress following suicide loss. While the Air Force has acknowledged postvention's significance in suicide prevention efforts, it has yet to incorporate practical applications for clinicians. Postvention support for the workforce will reduce adverse outcomes and build the morale of a unified and cohesive healthy team.

The United States Department of Defense has focused on mental health for decades. Its early policy established the rights of service members referred for mental health evaluations, a requirement from the National Defense Authorization Act (NDAA) for fiscal year 1993.[1] The 2006 NDAA enhanced the prioritization of mental health, directing the establishment of a task force to examine mental health.[2] The subsequent report found DOD efforts at the time to be significantly lacking and created actionable recommendations to address the shortfalls, such as providing access to quality care, dispelling stigma, developing psychological resilience, and promoting empowered leadership, culture, and advocacy for psychological health.[3] Since the 2006 legislative document, mental health is mentioned in each subsequent NDAA, reflecting the growing recognition of the importance of mental health support for the military population.

Still, despite this focus, the annual rate of suicide among service members continues to rise, as noted in the Defense Department's recent *Annual Report on Suicide in the Military, Calendar Year 2023*.[4] And with this rise, there is a missing data point not discussed: the state of the mental health community that supports "at-risk" service members. Mental

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1. National Defense Authorization Act (NDAA) for Fiscal Year 1993, Pub. L. No. 102-484, 106 Stat. 2315 (1992), Sec. 546.

2. NDAA for Fiscal Year 2006, Pub. L. No. 109-163, § 723, 119 Stat. 3136 (2006).

3. Alan Berman et al., *The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives, Final Report of the Department of Defense* [DOD] *Task Force on the Prevention of Suicide by Members of the Armed Forces* (DOD, August 2010).

4. Defense Suicide Prevention Office (DSPO), *Annual Report on Suicide in the Military, Calendar Year 2023* (DOD, Under Secretary for Defense and Personnel Readiness, 2024), https://www.dspo.mil/.

health professionals are indispensable in shouldering the immense emotional burdens of the nearly 3.4 million service members who voluntarily serve this nation.[5] As the demand for clinical mental health services rises, clinicians must receive the appropriate support to maintain their well-being and prevent adverse outcomes.

The Department of Defense continues to invest substantially in suicide prevention and awareness programs with minimal focus on the healthcare community. Response to a death by suicide within the military community is targeted to family, friends, and the unit, without much thought given to the healthcare team. This gap is also apparent in the literature, programming, and resources for clinicians across the healthcare space.

For the clinician, experiencing a patient's death by suicide has significant personal and professional impacts.[6] The range of emotions experienced by impacted clinical teams is often exacerbated by the lack of systematic support available in the aftermath of a patient's death. To address this gap in service, the Defense Department must include vital postvention resources not only to support military healthcare professionals, but also to align enterprise high reliability and readiness priorities. Implementation of such programs will provide measures for a strong organizational culture and climate, preparing the military healthcare community and their organizations to respond appropriately following adverse events and to enable them to support the well-being and readiness of service members.

## The Impact of Suicide Loss

The impact of suicide on clinicians has been identified as an unintended consequence of the profession, with no systemic mechanism to support the ramifications of suicide. These consequences leave providers feeling unattended and unsupported, and they are expected to return to work as if nothing has occurred. This creates a community experiencing the toils of burnout, now exacerbated by morally injurious events without the opportunity for healing and growth. The impact following the death of a patient by suicide is comparable with other traumatic life events, and the healthcare system's approach to staff support must be in line with the same level of quality care afforded to the patients they serve.

The emerging research demonstrates the value in providing institutional opportunities for effective coping with suicide loss, which can lead to posttraumatic growth. Posttraumatic growth refers to the idea that traumatic experiences can present an opportunity for critical self-reflection and self-improvement.[7] Healing and growth can only be achieved when they are deliberately aligned to help clinicians endure loss, reduce self-blame, and maintain

5. DOD, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, *2022 Demographics Profile of the Military Community* (DOD, 2022).

6. Nina Gutin, Vanessa L. McGann, and John R. Jordan, "The Impact of Suicide on Professional Caregivers," in *Grief After Suicide: Understanding the Consequences and Caring for the Survivors*, ed. John R. Jordan and John L. McIntosh, 1st ed. (Routledge, 2010).

7. Richard G. Tedeschi and Lawrence G. Calhoun, "The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma," *Journal of Traumatic Stress* 9, no. 3 (1996).

a solid professional self-efficacy.[8] This process is captured through postvention, a proactive approach to mitigate the impact and cumulative stress following suicide loss, and is essential for clinicians to cope with the emotional tolls of this loss.[9] Not only can the emotional impact of patient suicide have significant impacts on the professional, but also those impacts have negative implications on military readiness. These personal impacts extend from the emotional toll seen through grief, depression, humiliation, fear, anger, and disordered sleep to professional impacts leading to self-doubt, decreased self-confidence, and further adverse outcomes.[10]

The Military Health System (MHS) continues to adhere to the high reliability framework that is based on process design, building culture and structures that promote safety, and improving outcomes. The principles of a high reliability organization for the MHS are primarily focused on achieving system effectiveness in support of providing a safe and quality patient experience to its beneficiaries. As the intended outcome surrounds the care provided to the patient, there are principles that focus on the healthcare environment and the promotion of a culture of mindfulness and responsibility of the staff. The MHS has taken an admirable approach to achieving top outcomes with a patient-centered focus yet with a nominal focus on the health and wellness of the staff providing quality care.[11] A logical next step for the MHS as continuous process improvement and advancing a ready, reliable workforce must include support and resources to staff. The Defense Department must look to realign its initiatives to properly support the workforce through postvention, thus reducing adverse outcomes and fostering a unified and cohesive healthcare team.

## Suicide in the Department of the Air Force

Suicides in the Department of the Air Force have gradually increased since 2011, reflecting the overall trend of the US population. While DAF data shows a lower rate than the matched US population, suicide remains the leading cause of death in the department. The 2023 DOD *Annual Report on Suicide in the Military* indicates a gradual increase from 2011 to 2023 across all branches.[12] The demographics for those who die by suicide have remained consistent, with most of these losses being enlisted males under the age of 30.

The Defense Department captures data following a death by suicide using the DOD suicide event report, which shows that 42 percent of those who died by suicide had one

8. John L. McIntosh, *Clinicians As Survivors of Suicide: Bibliography* (American Association of Suicidology Clinician Survivor Task Force, 2019).

9. Edwin S. Shneidman, *Suicidology: Contemporary Developments*, Seminars in Psychiatry, ed. Milton Greenblatt (Grune & Stratton, 1976).

10. Madison Jupina et al., "Prevalence of Patient Suicide and Its Impact on Health Care Professionals: A Systematic Review," *Psychiatric Services* 75, no. 10 (2024), https://doi.org/.

11. Shari Silverman and Meaghan Meeker, "Ready Reliable Care: The Defense Health Agency's Approach to High Reliability," *Management in Healthcare: A Peer-Reviewed Journal* 8, no. 3 (2024), https://hstalks.com/.

12. DSPO, *Annual Report*.

or more mental health diagnoses. In the year before death, just 39 percent of decedents sought clinical mental healthcare, 33 percent sought support from a non-medical helping agency, and 15 percent sought care with a chaplain.[13] Unfortunately, suicide decedents underwhelmingly utilized available healing resources.

Part of the issue lies with the general stigma associated with mental health issues and suicidal ideation in particular. Per the CY23 *Annual Report*, 42 percent of those who died by suicide had documentation of one or more mental health diagnoses, 44 percent had an intimate relationship problem, and 24 percent had workplace difficulty.[14] Yet, individuals continue not to seek care as they believe it will negatively affect their careers. For example, despite DOD strategic messaging indicating that seeking mental health support does not pose a risk to keeping or gaining a security clearance, some service members and their families remain reluctant to come forward.[15] Those who do seek care are resistant to disclosing the true nature of their risk for fear of career implications.

For the 39 percent of decedents who did utilize clinical mental healthcare, the aftermath is a healthcare team managing profound sadness, guilt, shame, self-doubt, and fear regarding personal litigation. A systematic review of the impact of suicide on healthcare professionals found that more than half of those experienced a patient suicide.[16] Following the suicide death of a patient, professionals' clinical judgment and confidence can be affected, manifesting through hypervigilance in their clinical documentation, increased hospitalization for at-risk patients, overall avoidance of patients who may be suicidal or deemed at-risk, or succumbing to the burnout and leaving the career field altogether.[17]

The Air Force has made significant strides toward policy and programming for suicide prevention and awareness, as captured in DAF Instruction (DAFI) 90-5001, *Integrated Resilience*.[18] This policy describes postvention as a critical support option for individual and unit resilience and refers readers to a resource created to guide leaders following a unit suicide. Another policy focusing on response to traumatic events is DAFI 44-153, *Disaster Mental Health*, which outlines helping agencies' response capabilities in an all-hazard incident.[19] This policy focuses on supporting the community or unit following the event. Yet despite these policies, postvention within the DAF remains an abstract principle, one lacking resources and guidance on how to enhance relevant knowledge and

13. David Roza, "Air Force Publishes Sweeping Analysis of Suicide Deaths in 2020," *Air & Space Forces Magazine*, 19 March 2024, https://www.airandspaceforces.com/.

14. DPSO, *Annual Report*.

15. Janet A. Aker, "Get the Facts About Mental Health and Security Clearances," DOD [website], 3 October 2024, https://www.defense.gov/.

16. Jupina et al., "Patient Suicide."

17. David M. Sandford et al., "The Impact on Mental Health Practitioners of the Death of a Patient by Suicide: A Systematic Review," *Clinical Psychology & Psychotherapy* 28, no. 2 (2021).

18. Department of the Air Force Instruction (DAFI) 90-5001, *Integrated Resilience* (DAF, 23 July 2024).

19. DAFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control* (DAF, 6 August 2010, certified current 26 August 2014).

skills. Regardless of the postvention resourcing, the current DOD and DAF policy needs to pay more attention to the support of the healthcare team.

## Military Mental Health

The DOD mental health community comprises multidisciplinary teams that include social work, psychology, psychiatry, nurse practitioners, nurses, and mental health technicians. Within the Defense Department, these professionals are aligned with military treatment facilities that provide quality care to the beneficiaries in their catchment areas. Due to the growing demand and low supply of manpower, these clinics are relegated to primarily providing outpatient mental health clinical care to service members, with nonuniform beneficiaries being referred for care within the civilian network. The DOD mental health clinics manage patients for a range of mental health conditions and disorders.

A 2023 Defense Health Board report noted that the Department of Defense continues to be challenged by the existing national "mental health crisis" and the Military Health System "lacks the resources it needs, in terms of providers and treatment options" to meet the needs of the military.[20] Similar language appeared in the 2006 DOD task force on mental health recommendations report required by the NDAA.[21] Furthermore, from 2019 to 2023, the armed forces health surveillance division reported anxiety disorders among military members were observed with the largest increase, nearly doubling from previous surveillance periods.[22] The mental health crisis remains present, where access to clinical mental healthcare has doubled over the past decade, while manpower has remained stagnant.[23]

DOD mental health professionals are at the helm of the armed forces' psychological readiness and carry the burdens of those they care for in their communities. In general, mental health professionals face significant challenges in serving their community. Within the military, these professionals confront additional challenges because of their unique circumstances.

Mental health professionals constantly work within a professional space of high emotional burden and heightened vulnerability due to the inherent ambiguity in their work. Unlike their colleagues in family medicine, these professionals lack objective diagnostic tools like laboratory results or X-rays for clinical diagnosis and determination, increasing the complexity and nuance of the profession. They must rely on their clinical judgment, which is inherently subjective. Relying on their expertise and experience, they conduct assessments determining the safety and welfare of a vulnerable population under insur-

20. *Beneficiary Mental Health Care Access* (Defense Health Board, 28 June 2023), 5, https://health.mil/.

21. DOD Task Force on Mental Health, *The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health: Report to Congress* (DOD, 19 September 2007), https://health.mil/.

22. "Diagnoses of Mental Health Disorders Among Active Component U.S. Armed Forces," *MSMR* [Medical Surveillance Monthly Report] 31, no. 12 (2024), https://www.health.mil/.

23. Elisha Parkhill Pippin, "Mental Health Professionals Overlooked in Air Force's Resilience Push," *Air Force Times*, 20 May 2024, https://www.airforcetimes.com/.

mountable uncertainty. Upon conclusion of each appointment, the clinician may wonder if they missed something or if they diagnosed correctly, and the burden of "what if" pertains to the possibility that the patient may exercise free will and engage in self-harming behavior. This emotional burden alone can lead to anxiety, self-doubt, guilt, risk of vicarious trauma, and compassion fatigue.[24]

Unique to the military health workforce is that it encompasses two distinct professions: the profession of medicine and the profession of arms. There is an ethical tension in the duality between these two professions; the profession of medicine focuses on preserving life, and the profession of arms focuses on managing violence, which can involve death.[25] The exceptional, independent profession of military mental health has specialized expertise even within the medical community. Military mental health professionals manage the delivery of healthcare to their patients and the occupational health of the mission. Sometimes, there is a conflict between the two, and providers must use their clinical judgment through a national security lens.

The complexity of this profession and the reliance on clinical judgment alone without objective diagnostic tools create a remarkable challenge, which is often overlooked by those outside the field. Yet over the past decade, the demand for military mental healthcare skills has continuously increased while clinicians have not received support to manage the growing requirements. As the Defense Department falls short of effectively staffing, empowering, and caring for the mental health workforce, these professionals tend to feel neglected.[26] Members of the workforce can feel overwhelmed and unable to meet their basic mission requirements, which is then compounded in the wake of experiencing a patient loss to suicide, where the system lacks a mechanism to provide adequate support. Department-level policy must prioritize these efforts to empower this community to utilize available resources and determine if additional resources are necessary.

Resources for mental health professionals in the military are limited due to conflicts of interest in seeking care within their small professional community. They can utilize the non-medical resources available to all service members—for example, Military OneSource, Military and Family Life counselors, the unit chaplain—but these, too, are also experiencing limitations in capacity. As with most healthcare providers, mental health professionals are historically poor patients in that they delay seeking services for themselves either because they feel they cannot get away from the clinic or they do not have a confidential space to seek care.[27] There is significant literature that suggests healthcare providers often

24. Diarmuid MacGarry et al., "The Impact of Patient Suicidal Behavior on the Personal and Professional Well-Being of Mental Health Providers: A Systematic Review," *Clinical Psychology: Science and Practice* 29, no. 2 (2022): 100, https://psycnet.apa.org/; and Jupina et al., "Patient Suicide."

25. DOD Instruction 6025.27, *Medical Ethics in the Military Health System* (DOD, 8 November 2017), https://www.esd.whs.mil/.

26. See Pippin, "Mental Health Professionals."

27. Karen Jowers, "Services Detail Plans to Beef Up Mental Health Services for Troops, Families," *Military Times*, 31 May 2022, https://www.militarytimes.com/.

neglect their own physical and mental health despite being trained on the negative implications of delaying care.[28]

One study found physicians are hesitant to seek healthcare and have difficulty being in the patient role, leading to inappropriate self-care and pushing through illnesses. Such physicians were less likely to adhere to treatment recommendations for themselves than for their patients, even when they had a chronic illness.[29] Healthcare professionals are at high-risk for stress and burnout and often are caught in the physician-patient paradox, where they prioritize their patients' health over their own. Healthcare systems—and the MHS is no exception—must prioritize the health and well-being of their medical staff and provide resources appropriately to maintain professionalism and deliver high-quality patient care. Training and education throughout a clinician's lifespan to prepare them for the complexity of military mental healthcare are essential.

## Need for Postvention

Postvention is a mechanism to provide this critical training and support for mental health professionals. It is an aspect of suicide prevention and is a requirement for this vulnerable population of clinicians who are managing caseloads of high acuity and at-risk patients. First defined in 1968, postvention is an intervention conducted with survivors who experience patient suicide.[30] Postvention is essential to the MHS priority of being a high reliability organization, as it directly aligns with organization principles. For example, developing a comprehensive postvention protocol aligns with prioritizing safety. With the implementation of postvention, healthcare organizations experience improved safety and reliability by identifying and addressing potential risks and vulnerabilities, enhanced transparency and accountability through standardized procedures and protocols for sentinel events, and promotion of continuous improvement.[31]

Throughout postvention literature, most suicide postvention initiatives are focused on family and friends of the deceased, and within the Department of Defense, such initiatives are also focused on the inclusion of the unit—with interventions geared toward

28. Jo Best, "What's It Like to Be a Patient as a Doctor?," *BMJ: British Medical Journal* 387 (2024), https://doi.org/; and Hui Wang et al., "What Determines Healthcare Workers to Seek Professional Psychological Support? A Cross-Sectional Study," *Journal of Advanced Nursing*, ahead of print, 7 October 2024, https://doi.org/.

29. William T. Thompson et al., "Challenge of Culture, Conscience, and Contract to General Practitioners' Care of Their Own Health: Qualitative Study," *BMJ* 323, no. 7315 (2001): 728, https://doi.org/.

30. Matthew D. Erlich et al., "Why We Need to Enhance Suicide Postvention: Evaluating a Survey of Psychiatrists' Behaviors After the Suicide of a Patient," *The Journal of Nervous and Mental Disease* 205, no. 7 (2017), https://doi.org/.

31. Dorothy E. Stubbe, "When Prevention Is Not Enough: The Importance of Postvention After Patient Suicide," *Focus* 21, no. 2 (April 2023), https://doi.org/; and "Provide for Immediate and Long-Term Postvention," Suicide Prevention Resource Center, accessed 3 March 2025, https://sprc.org/.

commanders and unit members—without a focus on healthcare teams.[32] A 2015 RAND report identified a lack of evidence on how to approach clinician-focused postvention best.[33] As one review notes, "Clinician postventions' primary purpose is to mitigate adverse outcomes and enhance growth among clinician survivors" with the secondary focus "on preventing future patient suicide loss."[34] To support a system of clinicians, a formalized and comprehensive approach is needed to implement protocols focused on training and emotional support for those impacted by patient loss.

Currently, in DAFI 90-5001, the DAF has identified postvention as one of the 15 elements of its suicide prevention program, which is focused on the impact of suicide on coworkers, families, and friends.[35] The Defense Suicide Prevention Office (DSPO) has created a *Postvention Toolkit for a Military Suicide Loss* as a guide highlighting resources available when responding to deaths by suicide.[36] This has provided a comprehensive approach for military leaders, unit, and community members to navigate a loss and the complexities of now being a survivor of suicide loss. There are commonalities related to the emotional response of all survivors, but there are unique challenges experienced by clinicians engaged in the treatment of a patient who died by suicide. These include professional boundaries, which can make it difficult to process emotions; a sense of responsibility, which can lead to guilt, shame, and self-doubt; an investigative nature following sentinel events—or unanticipated events that result in death or other serious harm to patients—which can exacerbate stress; and the organizational response, which includes policies and procedures that often facilitate a return to normal behavior and approach.

There is no debate that the DOD clinical community faces a gap in postvention. Yet the gap can be filled with effective policy and programming that drives a community of care, compassion through education, and informal and formal support.

## Postvention Program Development

The development of a clinician-focused postvention program must be conducted with the understanding that there are specific and different staff needs based on one's closeness to the decedent. Approaches to clinician-focused postvention can be outlined and organized in various manners, either focused on the program component, intended audience, or timeline post-incident. This article's outline is based on critical elements. It then captures a time-based approach, serving as a guide for a useful program that can be implemented across the Military Health System.

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32. See, for example, Kelly A. Daly et al., "Scoping Review of Postvention for Mental Health Providers Following Patient Suicide," *Military Medicine* 189, no. 1–2 (2024); and Rajeev Ramchand et al., *Suicide Postvention in the Department of Defense: Evidence, Policies and Procedures, and Perspectives of Loss Survivors* (RAND Corporation, 2015).

33. Ramchand et al.

34. Daly et al., "Scoping Review."

35. DAFI 90-5001.

36. DSPO, *Postvention Toolkit for a Military Suicide Loss* (DOD, 2020).

There is no specified model for postvention, as the most effective method may vary depending on the situation, population, need, individual, and organizational context; however, key components are critical for implementing an effective, comprehensive postvention program within a suicide prevention program. These include policy and processes capturing formalized education and training, relational support, and organizational culture.

## *Formalized Education and Training*

The first component of formalized education and training is critical for clinicians to offer universal preparedness for patient suicide. This preparedness should capture varying scopes of the professional to ensure the variety of roles clinicians serve are covered. For example, a clinician supervisor versus the decedent's clinical provider will require different support and resources. Gaining an understanding of the personal impact of patient suicide focuses on the emotional toll that is commonly expressed through grief, guilt, shame, and self-doubt. Also, appreciating the professional impact of suicide can lead to a change in how a clinician conducts their practice, such as becoming more cautious, using consultations more frequently, documenting at-risk patients, or avoiding them altogether. The impact, personally and professionally, can be so significant that they elect to leave the profession.

Being able to recognize and manage secondary traumatic stress is critical for both individual and supervisory awareness to protect the health of the staff from stress that may occur following patient loss. Throughout postvention education and training, the Defense Department must provide the overarching knowledge and skills that eliminate assumptions of what the signs, symptoms, and risk factors of secondary traumatic stress are; how to self-assess, monitor, and address this stress; and how to create an environment of care and compassion, where staff feel supported and encouraged to heal and move through their grief.[37] Training these clinical teams on posttraumatic growth skills where they experience positive transformations regarding self-perception, interpersonal relationships, and overall well-being provides a window of hope for those who have the unfortunate experience of patient loss to suicide.

## *Relational Support*

The next component of relational support has been shown to reduce the impact of grief. Social connections are vital for emotional healing and recovery.[38] Traumatic events often leave individuals feeling isolated, lonely, and disconnected, and relational support provides a safe space to process emotions and reduce this isolation. Postvention research frequently promotes a peer-support model, a defined support system founded on respect, shared

37. *Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision* (National Child Traumatic Stress Network, 2018), https://www.nctsn.org/.

38. Tina M. Mason, Cindy S. Tofthagen, and Harleah G. Buck, "Complicated Grief: Risk Factors, Protective Factors, and Interventions," *Journal of Social Work in End-of-Life and Palliative Care* 16, no. 2 (2020), https://doi.org/.

responsibility, and mutual agreement. Providing peer support requires a certain amount of skill, knowledge, and self-awareness surrounding one's capacity to adequately support someone in need. Another component of relational support is the role of the supervisor, who has a unique opportunity to guide and direct during challenging days. Critical competencies for supervisors of clinical teams include providing a safe, nonjudgmental space, supporting performance management by adjusting their workload and responsibilities, being transparent about roles and responsibilities, and monitoring their well-being while connecting to resources as appropriate. Respectfully navigating these competencies, a supervisor can support the impacted individuals while cultivating an organizational culture that values care and compassion.

## *Organizational Culture*

The third component captures the complexities of healthcare settings, which require a strong organizational culture, referring to the shared values, beliefs, and assumptions that shape organizations.[39] Through culture, an organization gains a sense of purpose and unity, which provides a foundation for being more equipped to cope with complex and dynamic challenges when they arise. The mental health clinical setting is complex, with misaligned staffing ratios, rising demand for clinical services, and a move toward pathologizing the human experience, thus further driving demand, clinician burnout, and other challenges. Navigating these challenges requires leadership that prioritizes and understands the need for a positive organizational culture. Prioritizing employee well-being, open communication, community, and colleague connection drives the quality of life and care.

The organizational climate reflects the staff's perception of the organizational culture. Both culture and climate are critical to the healthcare setting as they are connected to morale, adverse action rates, burnout, turnover, and overall patient safety and quality care.[40] An organization communicating cultural aspects increases the likelihood of a cohesive and stable workforce. Clinical leaders are responsible for influencing organizational culture and designing strategies to operationalize it, forming the climate. This influence toward a positive organizational culture and climate comes through clear and consistent messaging of the values and principles, creating an environment that promotes wellness and resilience.

The abovementioned components are not exhaustive but capture foundational information for postvention policy and programming to be built upon. The DSPO postvention model takes a three-phased approach, developed by the Tragedy Assistance Program for Survivors, an organization that offers resources to those grieving the loss of a military member.[41] This approach guides those who engage with survivors of suicide to move

39. Richard Chalmers and Grace D. Brannan, *Organizational Culture* (StatPearls Publishing, 2020).

40. Janet C. Berry et al., "Improved Safety Culture and Teamwork Climate Are Associated with Decreases in Patient Harm and Hospital Mortality Across a Hospital System," *Journal of Patient Safety* 16, no. 2 (2020), https://doi.org/.

41. DSPO, *Postvention Toolkit*.

through their grief journey with the primary focus on stabilization, on the facilitation of healthy grieving, and then finally toward achieving posttraumatic growth. Within this framework (table 1), time-based tasks can be added to clarify critical tasks, such as notification, initial support, risk assessment, peer support, and follow-up. A military clinician-focused postvention program that has an evidence-based, trauma-informed policy and provides the flexibility to achieve the outcome of supporting mental health professionals will enhance the morale, retention, and overall readiness of this critical workforce.

**Table 1. Postvention approach for military health professionals**

| CLINICIAN FOCUSED POSTVENTION FRAMEWORK | | | |
|---|---|---|---|
| **Postvention Component** | **Formalized Education and Training** | **Relational Support** | **Organizational Culture** |
| **Purpose** | Offer universal preparedness and overarching knowledge and skills. | Peer and supervisor role and responsibility to provide safe, non-judgmental support. | Shared values, beliefs, and assumptions that shape organizations and provide sense of purpose and unity. |

Implementation of a postvention program requires effective policies and processes to support individuals and organizations following a traumatic event. Through effective policy, organizations are prepared because of the planning efforts to address individual and organizational needs. This framework guides individuals and organizations in the wake of a patient's loss and allows for a consistent approach regardless of who is involved. A policy that captures postvention bolsters the workforce's well-being and prioritizes the value of engagement and support toward healing. Additional elements of effective policy to consider are clearly defining terms and goals of postvention, identifying a clear scope and roles and responsibilities with specific response procedures outlining support services and communication plans, and allowing evaluation and review of program effectiveness while identifying areas for improvement.

Implementing such a program is limited by manpower constraints and available resources. Producing this program at an enterprise level alleviates some of these constraints, providing a plug-and-play model for DAF installations to implement. The workload can be manageable and effective with collaboration and coordination across helping agencies. This framework is currently being used by the author to develop a clinician-focused program for the Air Force surgeon general office. This program will serve as a stepping stone toward deliberate attention of providing support and resources to the healthcare community.

## Conclusion

The well-being of DOD mental health professionals is more than a human capital issue. There are direct implications for national security, and for the Department of the Air Force, there are implications for its overall readiness posture. The DAF relies on these professionals to provide quality care to Airmen and Guardians involved in national security efforts, and they deserve investment. Airmen and Guardians are experiencing stress,

and although this may be a normal part of the human experience and may not directly equate to being at risk for suicide, it is important to remember that the identified needs of those who die by suicide are treatable mental health concerns. This is a primary talking point of DAF suicide prevention training.

Postvention offers a mechanism for the enterprise to leverage evidence-based trauma-informed practices to support highly specialized professionals who voluntarily carry a heavy emotional burden on behalf of the nation's service members. As the DAF begins to align expectations of mental health with readiness, the next right thing requires systematic policy and programming efforts to support the mental health community intentionally and deliberately when they need help, especially after experiencing the loss of a patient. The lethality of the Air Force will be enhanced when it invests in its mental health community. With the optimization of the mental health community, the force will receive the high-quality care it deserves and requires to be successful.

The need for postvention resources is a readiness issue: readiness of the mental health community directly impacts the readiness of the force. Investment in the mental healthcare workforce is an investment benefiting the entire Air Force. ✈

# The Meaningful Connection Pathway Model

## Spiritual Waypoints to Prevent Suicide

Charles Seligman III

This article introduces the meaningful connection pathway model, which outlines the mechanisms of spiritual fitness. The model represents a new tool for the Department of the Air Force's (DAF) suicide prevention efforts, introducing spirituality as a meaning-making activity vital to warfighter readiness. Using the total force fitness framework and critical realism, the model aligns with DAF priorities, providing leaders with a replicable strategy and caregivers with a practical way to enhance well-being among Airmen and Guardians by preventing disconnection, fostering a safer, more cohesive military environment, and deepening connections to the self, others, and life. The model holds implications for the advancement of suicide prevention strategies as well as operational readiness across the national security spectrum.

How the Department of Defense—and specifically the Department of the Air Force (DAF)—define *spirituality* is integral to forming a strategy to prevent suicides within the service. The service components within the Defense Department are focusing on spirituality in a targeted emphasis to protect personnel. Such efforts are in line with current research, which indicate that higher levels of spirituality can offer protective factors against individuals acting on suicide ideations and suicide behaviors.[1] The US Army, for example, is investing in spirituality to increase connectedness as a prevention to social isolation and loneliness and grow positive relationships for personnel.[2] Likewise, the Marine Corps also highlights spirituality to its personnel as a way to increase connection through social support systems in an attempt to reduce suicide risk.[3] But what exactly does spirituality entail?

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1. See, for example, Tanya Aneja and Rita Kumar, "A Pathway to Healing: Exploring the Role of Spirituality as a Predictor of Suicidal Ideation," *Tuijin Jishu/Journal of Propulsion Technology* 44, no. 4 (2023), https://doi.org/; Eric B. Elbogen, et al. "Psychosocial Protective Factors and Suicidal Ideation: Results from a National Longitudinal Study of Veterans." Journal of Affective Disorders 260 (2020), https://doi.org; and Melissa A. Smigelsky et al., "Religion, Spirituality, and Suicide Risk in Iraq and Afghanistan Era Veterans," *Depression and Anxiety* 37, no. 8 (2020), https://doi.org/.

2. Chester Curtis, "Preventing Suicide Through Spirituality," US Army (website), 11 September 2021, https://www.army.mil/.

3. HQMC Behavioral Programs, Program Evaluation and Research, "Spirituality, Religion, and Suicide Risk," Marine Corps Community Services, accessed 12 February 2025, https://albany.usmc-mccs.org/.

Spirituality fosters meaning making, connectedness, and hope, all of which provide a framework for coping with life's challenges. Spirituality manifests within the connections that build social support between oneself and the broader community, meaning and purpose in one's life, and strong personal beliefs about oneself, others, and the world.[4] For military personnel, such spiritual factors increase hope and optimism and remain key to suicide risk reduction.[5]

In particular, such strong personal beliefs are an integral part of what the Department of Defense and Air Force refer to as *spiritual fitness*.[6] Chairman of the Joint Chiefs of Staff Instruction 3405.01, *Total Fitness Framework*, defines spiritual fitness as "the ability to adhere to beliefs, principles, or values needed to persevere and prevail in accomplishing missions."[7] It also points to the significance of fostering this aspect within service members, as "a strong spirit promotes resiliency and enhances one's ability to mitigate adverse responses to stress."[8] Although it does not offer a clear definition of spirituality, the instruction suggests that spiritual fitness and spirituality are synonymous: "Capturing spirituality's contribution to total fitness is essential to optimizing the well-being and resiliency of the total force."[9]

The DAF reiterates this definition and recognizes spiritual fitness as one of the four pillars of resilience in the comprehensive Airman fitness framework.[10] While it defines spiritual fitness as "the ability to adhere to beliefs, virtues or values needed to develop a fulfilling life with quality of service," it describes spirituality as "the means to find ultimate meaning and purpose in life."[11] Both of these definitions are supported within the Air Force chaplain corps as well, which has been officially acknowledged by the US government for its part in suicide prevention efforts. Recognizing the importance of fostering spirituality among service members, the government has tasked the chaplain corps to provide support services to service members and their families to help "in building and maintaining a strong family structure, or to support the resiliency, suicide prevention, or holistic wellness [of these individuals]."[12]

Yet while such guidance outlines spiritual fitness as an end-state that complements other fitness domains, it does not propose standard criterion for assessing spiritual fitness

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4. Kyle, "Spirituality."

5. C. J. Bryan, E. Graham, and E. Roberge, "Living a Life Worth Living: Spirituality and Suicide Risk in Military Personnel," *Spirituality in Clinical Practice* 2, no. 1 (2015), https://doi.org/; and see Smigelsky et al., "Religion."

6. Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3405.01, *Chairman's Total Force Fitness Framework* (CJCS, 2011, current as of 13 September 2013), A-2.

7. CJCSI 3405.01, A-2.

8. CJCSI 3405.01, A-E-1.

9. CJCSI 3405.01, D-4.

10. Department of the Air Force Instruction (DAFI) 90-5001, *Integrated Resilience* (DAF, 23 July 2024), https://static.e-publishing.af.mil/.

11. DAFI 90-5001, 79.

12. DAFI 52-101, *Chaplain Corps Planning and Organizing* (DAF, 29 November 2023), 18, https://static.e-publishing.af.mil/; and Chaplain-led Programs: Authorized Support, 10 USC § 1789.

or delineate the mechanisms that inform how an individual achieves it. Current evidence about spiritual fitness and readiness reveal that these definitions are outcome-focused and lack a contextual standard application. Discussion about suicide prevention thus has a vested interest not only in spirituality because of its contribution to total fitness and optimization of total well-being and resilience but also in related terms like *spirit* and *spiritual* as well, historically elusive words whose definitions are as varied as the context in which they are used.

This article proposes a model for tracing one's path toward healthy spirituality—referred to here as a *model of meaningful connections*—to help Airmen and Guardians and their caregivers understand how to foster a healthy spiritual self. In a different context—for example, in organized religion—spirit, spiritual, and spirituality can take on different meanings. In the context of the Air Force's comprehensive Airman fitness framework, however, they can be understood as *meaningful connections*, or what one analysis describes as the "subjective quality of relatedness to others so essential to bolstering well-being and quelling loneliness."[13] In outlining the development of spirituality and the stages of that process, this article provides practical suggestions for using the model for oneself or the caregiving of others to understand the wisdom and value of meaningful connections. While this article proposes this model of meaningful connections for reducing suicide risk in the DAF, it also recognizes that this process is one that remains open to development and conversation among Airmen, Guardians, and their leaders.

## The Theoretical Approach

Critical realism provides the context to understand the nature of one's spiritual existence and the relationship between the ideas of spirit, spiritual, and spirituality used in the proposed meaningful connection model. Critical realism is effective because it enables one to grasp a full understanding of reality as both observable and unobservable events. It also accounts for unseen forces acting on lived experience. As a theoretical approach, critical realism explains the sequential movement from spirit to spiritual to spirituality as a continual movement in one's life. Spirit, spiritual, and spirituality exist on a looping continuum as one experiences and responds to life events, ever evolving their spiritual self.

According to critical realism, reality is made up of three domains: the real, the actual, and the empirical. The real domain consists of underlying structures. The spirit is nested within the real domain, which is a place of origination that gives rise to the actual domain. The actual domain is where observed and unobserved events take place. The spiritual is nested within the actual domain; thus the spiritual state of humanity exists with all a person's responses to life events. Finally, the empirical domain is where an individual's personal experiences of events that have led to their beliefs and behaviors are now their lived truth. Spirituality, also known as the spiritual self, is nested in the empirical domain

13. D. Smallen, "Experiences of Meaningful Connection in the First Weeks of the COVID-19 Pandemic," *Journal of Social and Personal Relationships* 38, no. 10 (2021), https://doi.org/.

and is where individuals live out their tested spiritual beliefs and practices. One's spirituality, known as the spiritual self, is ever evolving and becoming as it is a product of the spiritual/actual domain.

Spirit, spiritual, and spirituality are best understood as sequential stages in one's journey toward spiritual fitness, with distinct milestones in each stage. Spiritual fitness starts with the movement toward meaning. The spirit creates and reinforces meaning-making activity toward the events of life. In some ways, the spirit can be likened to the core at the center of the Earth that is made up of hidden forces that actively drive everything above—it is largely unseen yet represents deep invisible structures that influence everything on the surface. The spirit is an underlying structure of causality that generates one's motivation to seek the meaning of life and meaning in life.

The spiritual stage consists of meaningful events, traits, behaviors, and discoveries that are products of the spirit's drive toward making meaning of life's events. The spiritual can be likened to the Earth's crust and mantle that rest just under one's feet, consisting of both observed and unobserved life events. Life's events are like geologic and tectonic shifts, volcanic eruptions that initiate a response in the form of thoughts, feelings, beliefs, and actions. Spiritual is an adjective describing an individual's spirituality but also a noun delineating the sense-making within their life. Individuals form beliefs, practices, and thoughts—many of them spiritual—about what is happening to them in an effort to make meaning. The spiritual is the phase of one's journey when they search for and test various thoughts, beliefs, and practices that enable them to make sense of the events of their lives.

Spirituality is best described as meaningful practices and beliefs that are developed from one's drive toward understanding life's experiences and the testing of specific beliefs, practices, and thoughts. These meaningful practices and beliefs can be understood as the spiritual self.[14] Spirituality is therefore like the Earth's surface—that observable part of reality where one lives, walks, breathes, and observes the world around them. Spirituality is that state where one lives out their spiritual underpinnings, whether that looks like religion, philosophy, or a general spiritualism. The meaning one has discovered rests just beneath the surface, becoming rich soil for one to live out their spiritual self. In this way, as beliefs and practices endure as true meaning for the individual, a sense of connection and spiritual fitness are reinforced.

## The Meaningful Connection Pathway

The meaningful connection pathway is comprised of six phases, as outlined below (fig. 1), that build upon one another and lead either to connection or disconnection. The phases represent states or conditions but also actions and movements. The pathway begins with the human capacity—or spirit—that moves individuals to think, feel, or act in a spiritual manner toward something or someone beyond themselves. In this way, people move toward

14. Joseph J. Amato et al., "Spirituality and Religion: Neglected Factors in Preventing Veteran Suicide?," *Pastoral Psychology* 66 (2017), https://doi.org/.

transcendence and enhance their meaning or embrace spirituality. Not only does this model define the phases in an individual's process toward spiritual fitness, but also these six milestones provide caregivers a way to diagnostically investigate one's spiritual struggle and engage as precisely as needed.

The phrase meaningful connections has three distinct connotations. First, each of the six phases along the pathway is meaningfully connected to the others. Second, the individual's ability to connect with what has happened in their life honestly and openly without denial enables one to discover deep truth. Finally, as humans journey through life, their discovery of self opens up a larger community of others that hopefully brings about meaningful connectedness as they inventory who or what has helped them along the way.

Figure 1 shows the meaningful connection pathway model with the six phases together and color coded to understand which waypoints along the pathway are associated with which of the three stages of the theoretical approach: spirit, spiritual, or spirituality. In this model, the spirit gives life to the living, optimizing well-being when it meets specific needs in each phase of the journey. Healthy spirituality, or spiritual fitness, is defined as meaningful connectedness, and this connectedness is achieved by successfully moving through each of the six phases. Key factors of spirituality are that it is essential in nature, it is actively engaged, it enhances flourishing, it is experienced as truth, it connects to a more powerful or knowledgeable other, it contains a larger reservoir of resources, and it heightens one's experience of truth and thus becomes the foundation of personal flourishing and warfighter readiness.

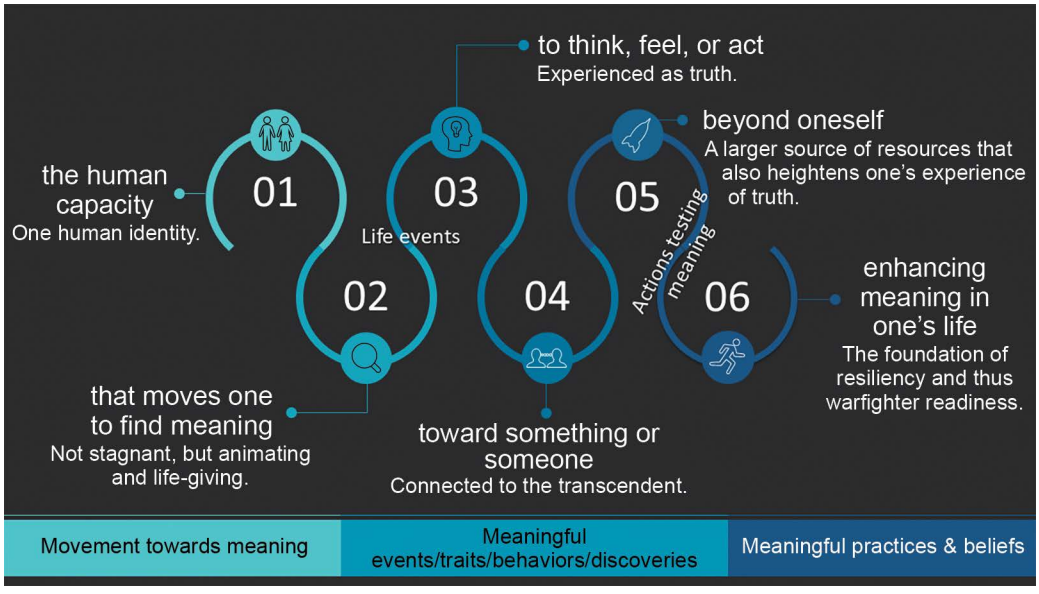


**Figure 1. The meaningful connection pathway model**

How might one understand what meaningful connectedness looks like and how that leads to flourishing and a healthy spiritual self that result in what the DAF defines as

spiritual fitness? In the following explanation, each waypoint along the spiritual pathway is defined in detail.

## *Phase 1: The Human Spirit*

The first phase involves the essential human capacity toward meaning making. This phase is the waypoint acknowledging that within all humanity resides the spirit, making all humanity spiritual beings. While there are many ways to define spirit, in the context of the Air Force's comprehensive Airman fitness framework, the spirit is best understood as a human quality everyone is born with that drives them toward meaning-making activity. The spirit is the source from which one desires and seeks meaning in life and the meaning of life. As a human quality, spirit is not necessarily a religious term, although a religious definition of spirit can co-exist with this understanding of a force within all humanity that provides an essential capacity to search for meaning. As mentioned above, the spirit is a motivational force that originates from the core of humanity, essential to the deepest part of the self.[15]

In this phase, a caregiver can start by assessing whether the Airman or Guardian accepts they are a spiritual person, as evidenced by the spiritual act of meaning making. Do they identify with an energy from within them, a spark from which special moments of connection and belonging to someone or something outside themself originate? One might ask them to define what it is about them that makes them spiritual or want to understand their life. Specific questions a caregiver can ask are provided in a latter section.

## *Phase 2: The Drive To Make Meaning*

Humanity searches, at some level, for meaning in and of life—an indication of the spiritual second stage. Therefore, everyone has the potential to achieve mature, healthy spirituality. Humanity's resting state is that of a traveler, recording all of life as a story.[16] The first truth of being human is that everyone has an inner drive to find meaning. To be human is to seek to know and understand oneself and the universe. Airmen and Guardians will sometimes say they are not spiritual, but the existence of such meaning-making activity reveals the presence of the spirit and the essentialness of the spirit because the spirit is the force that drives them to make meaning to understand life.[17] Humankind starts and spends

15. Patrick J. Sweeney, Sean T. Hannah, and Don M. Snider, "The Domain of the Human Spirit," in *Forging the Warrior's Character: Moral Precepts from the Cadet Prayer*, ed. Don M. Snider and L. J. Matthews (Jerico LLC, 2007); and Kenneth I. Pargament and Patrick J. Sweeney, "Building Spiritual Fitness in the Army: An Innovative Approach to a Vital Aspect of Human Development," *American Psychologist* 66, no. 1 (2011), https://doi.org/.

16. Brendan I. Cohn-Sheehy et al., "The Hippocampus Constructs Narrative Memories Across Distant Events," *Current Biology* 31 no. 22 (2021), https://doi.org/.

17. Sweeney, Hannah, and Snider, "Human Spirit."

their life on a journey of increasing meaningful connectedness by considering how they have responded to the events of their life and who or what has helped them along the way.

In this stage, a caregiver can continue their spiritual assessment by evaluating whether the Airman or Guardian accepts they are a spiritual person, as evidenced by the spiritual act of meaning making. Caregivers can also guide them in recognizing the role of life events in this meaning-making process. Traits, behaviors, and beliefs are formed through the events of life. Events that move an individual toward meaning typically move them internally; such events are specifically important and alter their course in life.

A caregiver can use narrative therapy techniques to have Airmen and Guardians diagram or write a timeline of the life events they believe helped to shape them. Writing out their life story is a powerful tool to help them consider what these events are. Examples of such events or moments that can initiate their search for meaning can range from something as momentous as the birth of their first child to the experience of a negative trauma event, and from something as seemingly inconsequential as the sound of trumpets at the beginning of the *Rocky* theme song to a view of a sunset or to the narration of a sermon, poem, or philosophical idea. When someone experiences these kinds of events, they interpret them in a unique and personal way. A caregiver can look for interpretative language. Many times, these interpretations are influenced by the following phases in the pathway.

## *Phase 3: Life Experienced as Truth, Leading Toward Understanding*

The spirit's motivation toward meaning making is catalyzed when one begins experiencing life events. Upon reaching the third stage of spirituality, individuals become self-aware and differentiate from others around them. One becomes cognizant of their own life events and memories, turns curious about ultimate causes, and begins asking, Why? These are different questions than what a toddler might ask. Such questions are more existential and ultimate.

In fact, a first response to the events of life is asking why. For example, if someone believes humanity is created in the image of God, they might believe the role of the spirit as the prime mover inside humanity—causing one to seek meaning—is that part of God's image that seeks to reunite humanity with the divine. To be human is to ask why bad things happen; why evil, hurt, and pain exist in the world; and why one must endure it? A caregiver can listen for these why questions as they interview Airmen and Guardians. Such questions tend to focus on what has happened in their life in the previous phase. These events are both joyful and traumatic and typically have significance in shaping individuals both positively and negatively. Caregivers can help them recognize the two factors that determine the effects of such shaping.

The first factor is the thoughts, feelings, and actions in response to the events of the Airman's or Guardian's life. These thoughts, feelings, and actions are also shaped by the events of life. This is where individual self-awareness is activated. Humanity is faced with a choice on how to respond in thoughts, emotions, and behaviors, based on the yearning to understand and make meaning of life events. A caregiver can look for ways in which

the Airman or Guardian has responded. Is it through arrogance or overconfidence or by rejecting others? Perhaps they medicate their pain with all forms of self-soothing. Maybe they choose to reach out to others, share the celebration, and laugh at their own situation. Individuals can decide to seek guidance or direction, study, or pray. Airmen and Guardians choose many ways to respond that will determine whether they stay connected and continue their journey toward meaning making or whether they become disconnected and experience loss of meaning.

## *Phase 4: Movement Toward Someone or Something*

Here the emphasis is on the movement of the individual as they recognize their part in a larger story in the universe. This alludes to the second shaping behavior—understanding that each individual is part of something bigger than themselves that creates a sense of awe and wonder that opens them up to a greater community outside the self. This sense of something larger than themselves allows for others to enter their situation, join the journey, and "be in relation," as one theologian writes.[18] That recognition leads an individual down the path toward the critical moment in the spiritual stage, or self-transcendence—to find someone or something to help make sense of the events of their life and inform thoughts that lead to healthy behavior.

This is known as a meaningful connection practice and offers caregivers an intervention through nonjudgmental, curious inquiry of the existence or awareness of these spiritual factors in the Airman's or Guardian's conscience. Specific examples of this inquiry activity are described in the practical implications and application section of this article, but generally, caregivers here explore the support systems and connections—or lack thereof—Airmen and Guardians share with others around them and within the broader context. They may feel a connection to bigger causes, larger purposes beyond themselves. Service in the military may be one of these larger causes and purposes of service. As mentioned, individuals are inclined, by their humanity, to seek meaning and to understand the events of their life, which lead them to think, feel, or act either toward or away from someone or something that can provide wisdom for interpretation, understanding, or empathy, which then leads them to want to make a greater impact. A caregiver can assess how the Airman or Guardian serves the world around them. Another way to facilitate this phase is to inquire where the Airman or Guardian has experienced awe and wonder in their life.

These connections are vertical if individuals come to believe in a higher power or philosophy for living. They are horizontal as they invite those in their immediate community into their lives to draw from a relationship, mentorship, coaching, or some other guidance. This meaningful connection can also be internal as individuals connect with themselves and recognize these experiences within a broader context and not deny their existence or replace them with false narratives.

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18. Colin E. Gunton, *The One, The Three and The Many: God, Creation, and the Culture of Modernity* (Cambridge University Press, 1993).

The caregiver can assess the efficacy of an Airman's or Guardian's support systems and their awareness of being part of a larger universal story. As this is done, they move toward phase five along the pathway.

## *Phase 5: Resources Beyond Oneself*

Phase five involves the movement toward a larger pool of resources that leads to a greater personal truth. This phase is tied to the previous phase of moving closer toward someone or something beyond oneself and is focused especially on the added resources this brings in closer proximity. Individuals discover new and broader resources outside of themselves that can be drawn from, and they begin to form new understandings about their experiences by looking back through the perspective of others in a community or with literature that offers insight, knowledge, or deeper understandings of life. They begin to realize community can be helpful, a life event unto itself. People do not need to walk the world alone, and they possibly discover the wisdom that joys are multiplied and difficult loads are lightened when shared with others. The additional perspective and resources bring new wisdom and interpretation toward meaning making. So as individuals continue to journey through the meaningful connection pathway, they test the meaningful truths they discover to determine their worthiness. From that testing comes new depths of meaning as experiences become understanding.

Through curiosity in conversation, caregivers stay observant to the Airman or Guardian, and through exercises, they foster an understanding of the resources that have helped the service member discover their current worldview. The caregiver should ask directly about support systems by taking note of the service member's family and social history, learning about their interests and hobbies and work life. Some formal assessment tools for exploring support systems and personal resources include the social support questionnaire, the multidimensional scale of perceived social support, the life satisfaction index, and the strengths and needs assessment. Most important is to understand the perspective of the Airman or Guardian. Understanding their core values—and values by which they live and how they came to believe in them—is the key to assessing this phase of the journey.

One now has many thoughts, beliefs, and ideas for how to act that are informed by the connections with self and others along with additional resources that can be brought to bear to determine the way forward toward meaning. While not a waypoint along the pathway, this part of the journey on the pathway has been taking place since phase 3, but it finds its fullness here. The Airman or Guardian acts in order to test meaning based on a hypothesis about their understanding of life; such tests give them information that will develop into one's truth or meaning in and of life. These will also turn into spiritual practices and can become what many know as religious, atheistic, agnostic, and philosophical worldviews.

## *Phase 6: Finding Ultimate Personal Meaning*

Finally, as one tests different thoughts and behaviors, enduring practices of spirituality form. Some of these behaviors result in religious practices, spiritual practices, and other

personal methods of coping and working out meaning in life and meaning of life. Therefore, the need in the spiritual stage is to develop healthy beliefs and practices that fulfill the drive toward finding meaning.

In the spiritual stage an individual will find it helpful to seek a guide, coach, mentor, or philosophy that aids in confronting difficult challenges that are larger than their ability to interpret them. In this case that individual has an opportunity to form healthy beliefs, values, and virtues from these events and prevent unhealthy distortions. In this way, spiritual states are tested, and if the thoughts, beliefs, and practices enable that individual to flourish, these spiritual states form traits that are their truth or worldview, and meaning is realized. This spirituality can then provide meaning in/of the world and can be understood as spiritual fitness.

A caregiver can assess for healthy beliefs and practices with curiosity and without judgment to determine how well each is helping the Airman or Guardian to flourish. Thoughts, behaviors, and practices define unique states of being for each individual. These states become ingrained traits and explain why individuals behave and believe in the way they do. Thus caregivers can further explore the Airman's or Guardian's core values. A clarity of personal core values reveals purpose. Values reveal beliefs and what feels true to the Airman or Guardian. A caregiver can ask how fulfilled they feel in their work, their personal life, their family, hobbies, and so on. Do they feel like they are nourished by their occupation, their community, their hobbies, or personal life? If not, what is interfering with that?

This meaningful connection pathway model is a way of understanding how meaning is developed and operationalized in relation to Airman and Guardian spiritual fitness. It incorporates the individual's natural drive toward meaning making. If the spiritual pathway connections occur in healthy and meaningful ways, then through testing one finds enhanced meaning about the events of life. One's interpretations along the way are influenced by their support systems, education, or some form of inspiration that can be self-guided understandings or divine intervention. These outside sources are often useful in providing additional resources outside oneself. In this way, two people can experience the same event but interpret that event differently according to their unique constitution, educational opportunities, and support systems, which serve to interpret their life events. Through the testing of thoughts, beliefs, and behaviors, one finds a way to understand and move through the world.

It is important to note that this process is never complete but circles back to any part of the pathway the Airman or Guardian needs when new events come into their life. In this way, their spirituality or spiritual self is not wrong because it is different from another; it is just uniquely formed. Caregivers thus may intervene at the same waypoints multiple times as each Airman or Guardian experiences their journey to spirituality in a continuous process. This idea of spirituality as an ongoing process supports the pluralistic context of the Air Force chaplain corps and is the foundation of human flourishing and warfighter readiness.

## Disconnection

The phases of healthy spirituality develop meaningful connections if the individual's needs are met in each phase. If so, then the successful completion of one phase leads one to the next and in a circular pathway through life. This dynamic of succession makes each of the six phases along the pathway meaningfully connected. The movement from one phase to the next provides for movement forward, backward, and continuously restarting toward a new journey of meaning making throughout the lifespan. Breaks in these six connections are shown in figure 2 between the latter phases of the process—between phases 3 and 4, 4 and 5, and 5 and 6. When breaks occur it means the Airman or Guardian has not reconciled the basic human need in the preceding phase, which creates a stuck point that negatively affects progress.

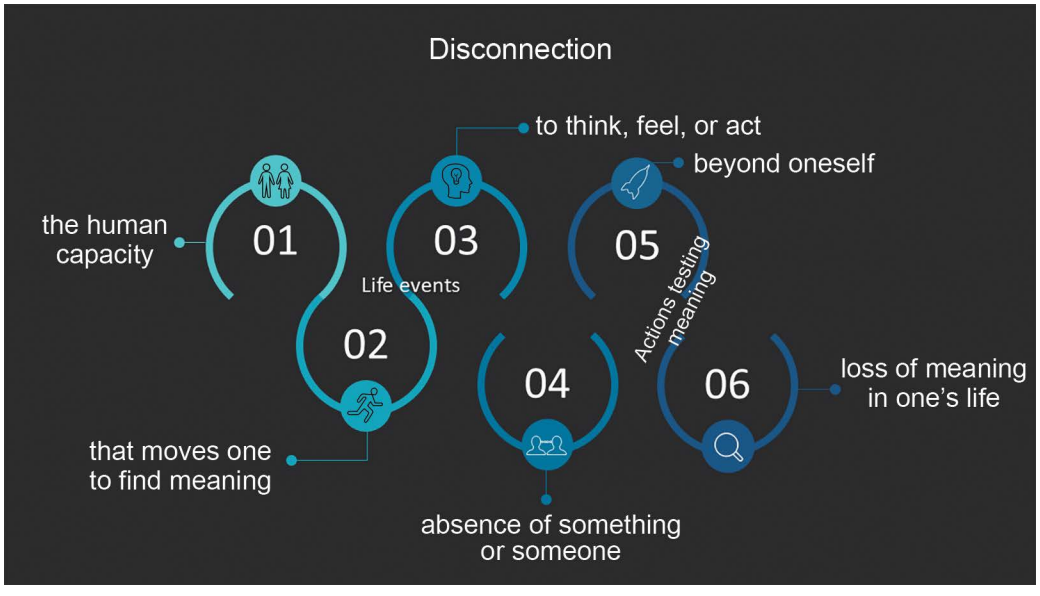


**Figure 2. Where disconnections happen along the pathway**

To illustrate disconnection, consider an individual who has experienced a difficult and overly challenging childhood. That individual is driven to understand the meaning of their difficult life, possibly leading to cognitive distortions or acting out behavior (breaks from phases 3 to 4). They find no one to help them understand and answer the why questions (breaks from phases 4 to 5), and they continue to think, feel, and act in ways that are counter to producing life within and finding meaning (breaks from phases 5 to 6). Such a person feels alone in their struggle to find anyone or anything beyond their self. A loss of meaning is experienced. In such a case, any intervention would start at the earliest disconnection point. As Airmen and Guardians can find support within their broader community, caregivers share the responsibility of their well-being with other caregivers. It is important to recognize that not every caregiver is adequately able to help every Airman or Guardian.

If their presenting issue cannot be resolved by the current caregiver, then they should be referred to another caregiver with adequate resources or life experiences to assist.

## Exploring Archetypes to Navigate the Pathway

Humans are shaped by one another, either by commission or omission. One's character is lived in community, contributing and receiving to and from one another. In the context of suicide, living in community is a deterrent to loneliness, recognized as an epidemic by the US Surgeon General Dr. Vivek Murthy.[19] Community is also essential to military leaders who rely upon the ability to organize groups of people toward the achievement of specific operational goals.

To live a meaningful life is to live a life in meaningful connection with one's self and others. Living in community compels people into places and situations where they can be encouraged, edified, and also challenged. Rubbing up against others informs the individual of their growing edges and the need for them, and it provides the individual with the personal resources to gain strength to overcome the challenges of life.[20] The significance of community is exemplified through the example of recently returned combat veterans, who are cited as having specific challenges with reintegrating into family, social, and community settings, placing them at higher risk of suicide.[21]

This dynamic of living in community can perhaps be best understood through the archetypal hero's journey present in storytelling and mythmaking as far back as the time of Odysseus and his passage through the narrow strait between Scylla and Charybdis. Such an archetypal motif endures in today's stories of heroes and the paths they have taken, whether it is in the narratives about Luke Skywalker, Frodo, Iron Man, or Batman. Archetypes in general serve as mirrors of the human condition, providing an excellent picture of how meaning making works. They enable one to understand universal aspects of the human condition across cultures and time as vehicles for humanity to experience the world, to experience a call to action, and to provide useful role models for how to carry forth that action.[22] And because of their larger-than-life portrayals of everyday human experience, they can provide impactful meanings that are relevant to today's Airmen and Guardians.

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19. Marissa King, "Working to Address the Loneliness Epidemic: Perspective-Taking, Presence, and Self-Disclosure," *American Journal of Health Promotion* 32, no. 5 (2018), https://doi.org/; and Vivek H. Murthy, *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community* (US Public Health Service 2023), https://www.hhs.gov/.

20. Bryan, Graham, and Roberge, "Living a Life."

21. Marek S. Kopacz et al., "Religious Coping and Suicide Risk in a Sample of Recently Returned Veterans," *Archives of Suicide Research* 22, no. 4 (2018), https://doi.org/.

22. Sophon Shadraconis, "Leaders and Heroes: Modern Day Archetypes," *LUX: A Journal of Transdisciplinary Writing and Research from Claremont Graduate University* 3, no. 1 (2013), https://scholarship.claremont.edu/.

In the hero's journey, the hero is often portrayed as rising from an ordinary life then overcoming some challenge or obstacle with the help of a mentor who guides them to find meaning, often amid a tragic situation. Such heroes must find themselves and define who they will be, what they will believe in, and what they will value and fight for. The hero's journey can be simplified into three phases: the departure, which outlines the journey within a larger context; the initiation, where the hero overcomes trials to prove their worthiness; and the return, where the hero resolves the initial crisis.[23] Significantly, the hero does not sojourn successfully by themselves but is accompanied by a wise person or mentor who calls them forth and guides the hero through their departure and initiation. As part of this process, sometimes the hero becomes the mentor for another departing on their own journey.[24]

This relationship can include both direct instruction to a protégé or one of influence through example that bonds the mentor and student together. In *The Iliad*, for instance, Achilles finds this bond with Patroclus. Achilles adjusts his own quest for honor and revenge by journeying with Patroclus and committing him to lead the Myrmidons into battle dressed in his armor. The meaningful connectedness between the two is evident in the grief Achilles experiences following the loss of Patroclus.

The meaningful connection pathway can be understood as akin to the hero's journey. From departure to return, the journey is filled with events and individuals intended to teach the hero some special knowledge that will help them resolve the crisis they confront. Often the greatest danger to the hero is manifested as the trickster archetype, which comprises the hero's inferior traits and represents their shadow reflection.[25] The hero giving in to their inferior traits can be equated to disconnection and the inability to find meaning, symbolized in the breaks that may occur along the pathway. But the defeat of the trickster enables the hero to overcome the crisis and fulfill the destiny they were called forth to achieve—which in the pathway is phase 6, spirituality.

Meaningful connections make it possible for every Airman and Guardian to transition from ordinary person to hero, in the sense that they are being called forth on an odyssey that will require self-sacrifice, hardship, and bravery, whether on the battlefield or in the conference room. This journey also applies to today's leaders, who must help other Airmen and Guardians make sense of their context, bring order to chaos, or right the wrongs of their unit.[26] There will be situations where a nemesis—whether in the form of a physical enemy or one's internal struggles—will seek to control the hero, standing in opposition to one's purpose. But meaningful connections gained throughout the journey will help Airmen and Guardians prevail. In the case of combat veterans who

23. See Joseph Campbell, *The Hero with a Thousand Faces*, The Collected Works of Joseph Campbell, Bollingen Series XVII, 3rd ed. (New World Library, 2012).

24. Bálint Szántó, "Mythological Archetypes in Marvel Film Adaptations," *AMERICANA E-Journal of American Studies in Hungary* 15, no. 1 (2019).

25. Szántó.

26. Shadraconis, "Leaders and Heroes."

are challenged by their recent return home from war, being called forth toward great feats is aided when they have others to travel alongside who invite them back into a shared community.

While heroes may suffer in crisis, lacking an understanding of their purpose and struggling in their search for meaning, they do not have to journey alone. Every organization has its share of mentor archetypes to call forth future heroes and guide them toward self-realization. Although Airmen and Guardians live in different ways with various philosophies of life that they have worked out for themselves along the pathway, the successful journey of every individual involves finding their community to discover meaning and to overcome the morally injurious experiences of life. In this way, spirituality, the product of the path of meaningful connections, becomes the way to find ultimate meaning and purpose in life.

## Practical Implications and Application

As community members intersect the lives of others who appear to have breaks in their meaningful connection pathway, one can refer to the six phases of the meaningful connection pathway model to diagnose and provide aid. The following are examples of the kinds of questions that are designed to engage Airmen and Guardians in a meaningful spiritual discussion based on the three domains, shown in parentheses.

- Where do you find meaning in your life? How do you define the meaning of life? What energizes you? (spirit, spiritual, and spirituality)
- Is there a spark from which special moments of connection to something outside yourself comes? (spirit)
- What spiritual traits, characteristics, or behaviors have you seen or participated in? (spirituality) This question helps caregivers understand how an Airman or Guardian has arrived at where they are and enables the service member to understand how their spirit is lived out and how it has formed. A caregiver becomes curious about the Airman or Guardian at this point and nonjudgmental while engaging them in meaningful conversation that focuses on them and distances itself from proselytizing, because the conversation is descriptive and not prescriptive.
- How do you understand or how have you interpreted the events of your life? (spiritual) The Airman's or Guardian's personal experience is important; however, the moments when someone is truly interested in another's personal experiences enough to ask may be rare. A caregiver can challenge them to consider that various people could look at the same event with a different interpretation of it, but that none are necessarily wrong. Their concept of the spirit will lead them to a conclusion about how they experience the spiritual in the world. This enhances respect and understanding while accentuating an appreciation of individual differences.

- How have you found a community or a sense of belonging to someone or something outside of yourself? (spiritual) This will directly influence what some believe to be a leading cause of suicidal ideation. It also speaks to transcendence without referencing it specifically.
- How has an event in your life helped you to be who you are today? How have you grown through the events of your life? (spiritual and spirituality) Readiness is enhanced through these engagements as caregivers help Airmen and Guardians tap into their spirit—that part of them that is common to all humanity—to give them a source of inner strength and a lens through which to interpret the events in their life. This provides perspective, which is a part of the Air Force's definition of spiritual resiliency.

In presenting the meaningful connection pathway as an explanation of healthy spirituality that leads to spiritual fitness, this article also offers caregivers other types of questions that may be helpful in understanding the process itself:

- Who or what should I connect with? Connections are vertical, with a higher being or higher understanding; horizontal, with other people including a unit leader or one's peers; and internal, such as with one's own emotions or physical sensations. Some answers may point to the importance of connection, the emphasis on the need to belong, or to connect to oneself or one's story. The connection is both outward and inward—"To know thyself" and "to thine own self be true."
- Why do we need connection? Possible responses might be to gain understanding, perspective, or wisdom, and to maintain a sense of community.
- What makes a connection meaningful? Ask, is the connection life-giving and helpful toward living in congruence with oneself and the community?
- Are there non-meaningful connections? In life's journey, those who help us in understanding the events of our lives are the guides, coaches, and helpers who increase meaning and enable us to find and appreciate things like awe, compassion, gratitude, love, inspiration, appreciation, among others.
- What happens when I am not connected? Some answers may include loss of meaning, loneliness, or isolation.
- Why do I need this? One answer may be that connection is part of our need to seek understanding that leads to meaning making. Perhaps asking how that statement challenges our thinking is important. Maybe that is where we need to begin.

Connection as a whole remains a public health strategy to protect individuals from the threat of suicide. For example, the Centers for Disease Control and Prevention have outlined

that connectedness happens in many social spaces and when utilized can deter suicide.[27] DOD and specifically DAF definitions of spirituality and spiritual fitness are based on the mechanisms of meaningful connections. The meaningful connections established along the journey to spiritual fitness, exemplified in the proposed model, can be used to deter suicide risk in the Department of the Air Force.

As government leaders in Congress have made suicide prevention a responsibility of the chaplain corps through Title X legislation, senior Air Force leaders have expanded resources inclusive of all comprehensive Airman fitness domains to add to the efforts of the Air Force surgeon general and Air Force integrated resilience. Integrating spirituality into the lives of service members and those they care about increases connection and belonging, creating a more supportive environment to combat the negative effects of disconnection and loneliness that increases suicide risk. ✈

27. National Center for Injury Prevention and Control, "Connectedness as a Strategic Direction for the Prevention of Suicidal Behavior" (Centers for Disease Control and Prevention, 2009), https://stacks.cdc.gov/.

# Resilience Expectations

## A Source of Hope or Harm?

Kimberly Dickman

The concept of resiliency remains theoretically contested, lacking a uniform or broadly accepted definition. Yet, dominant narratives continue to assert that adversity and trauma inevitably lead to strength and personal growth. A critical review of the literature on resiliency and posttraumatic growth reveals that discussions of resiliency, particularly in the context of military trauma and stress, often neglect the emotional complexities of these experiences. In suicide prevention and military mental health discourse, this omission may contribute to expectations of healing that could inadvertently cause harm rather than foster resilience. By acknowledging that the path from trauma to resilience is neither linear nor devoid of emotional distress, caregivers can promote realistic, improved outcomes for service members and their families.

From Nietzsche's famous aphorism, "Out of life's school of war—What does not destroy me, makes me stronger," to pop singer Kelly Clarkson's 2012 hit "Stronger (What Doesn't Kill You)," recurring messages are told that pain and suffering may hold transformative value.[1] These ideas often echo themes of finding a silver lining or following the narrative of biblical redemption, suggesting that enduring hardship can eventually lead to something good, even amidst trauma.

In one study that highlights how humans create meaning by crafting narrative identities, people are shown to naturally organize their experiences into stories, often emphasizing challenges, setbacks, and the ways they have overcome adversity.[2] One common theme another analysis identifies is the "redemption sequence," where negative experiences are reframed into opportunities for growth and positive outcomes.[3] This idea resonates across cultures and is evident in many of the myths and stories told around the world.

Joseph Campbell popularized the framework of the hero's journey, or the monomyth, which outlines a recurring narrative structure: the protagonist receives a call to adventure, faces tests and trials, endures ordeals, embarks on the road back, and undergoes transformation.[4] This journey serves as a metaphor for personal growth, resilience, and self-discovery.

There is growing recognition that resiliency plays a critical role in how individuals adapt to stressful life events. Resiliency serves as a protective factor against suicide by

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1. Friedrich Nietzsche, *The Twilight of the Idols, or How to Philosophise with the Hammer*, in *The Portable Nietzsche*, trans. Walter Kaufmann (Viking, 1954), 467.

2. Dan P. McAdams, "The Psychology of Life Stories," *Review of General Psychology* 5, no. 2 (2021), https://doi.org/.

3. McAdams.

4. Joseph Campbell, *The Hero with a Thousand Faces* (Princeton University Press, 2004).

enabling individuals to effectively cope with adversity, reducing feelings of hopelessness and despair.[5] Furthermore, resilient individuals typically possess stronger social support networks and problem-solving skills, factors associated with decreased suicidal ideation and behavior.[6] While research on resilience dates back nearly a century, it gained significant momentum around the turn of the twenty-first century with the rise of positive psychology.[7] The concept of "bouncing back" from adversity became a central focus in positive psychology.[8]

Various models have since emerged to address resilience in different contexts, including the sporting resiliency model for athletes, the resiliency wheel for educators, the adaptive capacity model for workplaces and organizations, and a resilience model tailored to the military context.[9] The field of resiliency research has expanded due to both scientific inquiry and practical applications, crossing disciplines and offering hope and inspiration to those facing adversity. These efforts reflect an ongoing search for models to explain human resiliency in all aspects of life.

Despite widespread use of the term, a uniform definition of *resiliency* has yet to be broadly accepted. Through a critical review of the existing literature on resiliency and posttraumatic growth, this article argues that discussions of resiliency, particularly in the context of military trauma and stress, often neglect the emotional complexities that accompany these experiences. In suicide prevention and military mental health discourse, this omission may contribute to undue pressure for service members to bounce back from difficult experiences or challenging circumstances—expectations that could inadvertently cause harm rather than foster genuine resilience. By acknowledging that the path from trauma to resilience is neither linear nor devoid of extreme emotional distress—including, for some, a profound loss of hope for the future—military leaders and caregivers can promote more realistic and better outcomes for service members and their families.

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5. Judith Johnson et al., "Resilience to Suicidality: The Buffering Hypothesis," *Clinical Psychology Review* 31, no. 4 (2011), https://doi.org/.

6. R. D. Everall, K. J. Altrows, and B. L. Paulson, "Creating a Future: A Study of Resilience in Suicidal Female Adolescents," *Journal of Counseling & Development* 84, no. 4 (2006), https://psycnet.apa.org/.

7. Martin E. P. Seligman and M. Csikszentmihalyi, "Positive Psychology: An Introduction," *American Psychologist* 55, no. 1 (2000), https://doi.org/.

8. Martin E. P. Seligman, *Flourish: A Visionary New Understanding of Happiness and Well-Being* (Atria Books, 2011).

9. Sahen Gupta and Paul Joseph McCarthy, "The Sporting Resiliency Model: A Systematic Review of Resilience in Sport Performers," *Frontiers in Psychology* 13 (2022), https://doi.org/; Nan Henderson and Mike Milstein, *Resiliency in Schools: Making It Happen for Students and Educators* (Corwin Press, 1996); Cynthia A. Lengnick-Hall, Tammy E. Beck, and Mark L. Lengnick-Hall, "Developing a Capacity for Organizational Resilience through Strategic Human Resource Management," *Human Resource Management Review* 21, no. 3 (2011), https://doi.org/; and Steven M. Southwick et al., "Resilience Definitions, Theory, and Challenges: Interdisciplinary Perspectives," *European Journal of Psychotraumatology*, 5, no. 1 (2014), https://doi.org/.

## Three Waves of Resiliency Models

The history of the study of resiliency helps to provide context for understanding the concept and for coming to a general consensus on the definition of the term itself. Resiliency inquiry is understood to have emerged in three distinct waves.[10]

### *Resilient Qualities (1970s–1990s)*

The first wave, Resilient Qualities, focused on studying survivors, primarily children, living in high-risk situations and sought to answer the question, What characteristics are needed to thrive in the face of adversity? This produced a list of internal and external qualities of individuals who bounced back from setbacks. A foundational study examined children who thrived despite multiple risk factors, highlighting personal characteristics such as being female, robust, socially responsible, adaptive, tolerant, achievement-oriented, good communicators, and possessing strong self-esteem.[11]

Similarly, a separate study of inner-city London youth identified resilient individuals as those with an easy temperament, a positive school climate, self-mastery, self-efficacy, planning skills, and warm, close relationships with adults.[12] Another significant contribution came from a study of children of parents diagnosed with schizophrenia, which found that those who became healthy adults shared qualities such as high expectations, a positive outlook, strong self-esteem, an internal locus of control, self-discipline, problem-solving and critical thinking skills, and a sense of humor.[13] Other studies both within and after this wave generated additional lists of personal traits that enhanced resiliency. A more recent example comes from the field of positive psychology, which describes resilient qualities such as optimism, faith, self-determination, wisdom, excellence, and creativity.[14] Overall, the first wave of resiliency inquiry helped identify assets and personal strengths of those who demonstrate resilience.

### *Resiliency Process (1990s–2000s)*

The second wave of inquiry, the Resiliency Process, presents a simple linear model of resilient qualities as a function of conscious and unconscious choices.[15] It focuses on the question, How are resilient qualities acquired? This resiliency model depicts a series of steps

10. Glenn E. Richardson, "The Metatheory of Resilience and Resiliency," *Journal of Clinical Psychology* 58, no. 3 (2002), https://doi.org/.

11. Emmy E. Werner and Ruth S. Smith, *Overcoming the Odds: High Risk Children from Birth to Adulthood* (Cornell University Press, 1992).

12. M. Rutter, "Resilience in the Face of Adversity: Protective Factors and Resistance to Psychiatric Disorder," *British Journal of Psychiatry* 147 (1985), https://doi.org/.

13. Norman Garmezy, "Resiliency and Vulnerability to Adverse Developmental Outcomes Associated with Poverty," *American Behavioral Scientist* 34, no. 4 (1991), https://doi.org/.

14. Seligman and Csikszentmihalyi, "Positive Psychology."

15. G. E. Richardson et al., "The Resiliency Model," *Health Education* 21, no. 6 (1990), https://doi.org/.

an individual completes to become resilient. Ideally, a person is in a state of biopsychospiritual homeostasis or has adapted physically, mentally, and spiritually to their circumstances. Yet, as life will bring, there are stressors, adversity, or life events that can threaten that homeostasis. Protective factors, such as those found in the first wave of resiliency inquiry, along with environmental and relational factors are used to address these life events. If protective factors are insufficient or stressors large enough, homeostasis is upset, and the person enters a phase of disruption. This model of resiliency then states that an individual has a choice in reintegrating from that disruption to come back to homeostasis. It acknowledges that lower functioning, to include dysfunctional reintegration, can occur, resulting in poorer outcomes compared to pre-adversity.

This model, however, also presents that growth can occur from adversity and disruption and can create resilient reintegration. This resilience from hardship helps to build protective factors that then help the person address future life events, making them more resilient. The Resiliency Process optimistically encourages disruptions as they can lead to insights and growth, or resiliency. Resilient reintegration states that individuals cannot only cope with disruption but can also grow and adapt through them.[16]

The second wave of resiliency inquiry includes the concept of innate resilience, which elicits some skepticism among scholars because it characterizes resilience as innate and static, ignores environmental and contextual factors, and thereby limits the potential for practical interventions aimed at improving resiliency.[17] It asks the question, What and where is the energy source or motivation to reintegrate resiliently? One study uses the disciplines of philosophy, physics, anthropology, psychology, sociology, and theology to support the theory that humans have energy or resiliency.[18] This theory states that there is a force within each individual that seeks self-actualization, altruism, wisdom, and harmony. This force is resiliency. The theory posits an innate self-righting mechanism that is the capacity for all humans to change and transform regardless of their risks.[19] Although the emergence of this perspective coincided with the postmodern era, it fundamentally addresses humanity's innate ability to endure and thrive, which has roots in centuries-old philosophical discourse.

## *Resiliency as Systems-Based and Multilevel (2000s–present)*

The third wave of resiliency inquiry, Resiliency as a Systems-Based and Multilevel Concept, expands beyond the individual to consider ecological, cultural, and systemic

16. Richardson.

17. Michael Ungar, "The Social Ecology of Resilience: Addressing Contextual and Cultural Ambiguity of a Nascent Construct," *American Journal of Orthopsychiatry* 81, no. 1 (2011), https://doi.org/; and Ann S. Masten, *Ordinary Magic: Resilience in Development* (The Guilford Press, 2014).

18. Ken Wilber, *The Marriage of Sense and Soul: Integrating Science and Religion* (Random House, 1998); and A. S. Masten, "Ordinary Magic: Resilience Processes in Development," *American Psychologist* 56, no. 3 (2001), https://doi.org/.

19. Werner and Smith, *Overcoming the Odds*; and Robert J. Lifton, *The Protean Self: Human Resilience in an Age of Fragmentation* (Basic Books, 1995).

influences on resilience. Social networks, policies, and cultural context are key to fostering resilience. The social ecological model of resilience envisions resiliency as a series of nested circles with biological systems at the core and psychological systems, the social environment, the built environment, and the natural environment, respectively, representing the outer rings.[20] Together these overlap to represent the complex system of influences. The model helps operationalize resiliency in the context of social and physical ecologies for individuals who encounter significant amounts of stress.[21]

These waves of resiliency inquiry did not end when the new wave emerged; rather, they continued and evolved, influencing each other. Each wave expanded the understanding of resilience rather than replacing previous perspectives. Contemporary resilience research recognizes and often integrates the insights from all three waves, reflecting a more comprehensive and multidimensional approach. This is true for the military as well.

Resilience is a key concept in military doctrine, yet its definition and application vary across different branches and strategic documents. Department of the Air Force Instruction (DAFI) 90-5001, *Integrated Resilience*, emphasizes resilience as a proactive and holistic approach, integrating mental, physical, social, and spiritual well-being to sustain readiness.[22] The Space Force, in particular, has challenged traditional definitions of resilience as merely bouncing back, instead promoting the concept of "bouncing forward" to reflect growth and adaptation in the face of adversity.[23] The Department of Defense's 2024 *Strategy for Resilient and Healthy Defense Communities* further reinforces resilience as a critical component of force readiness, linking it directly to mental health and suicide prevention efforts.[24] Understanding resilience through a military lens is essential for leaders, as it informs both personal well-being and the ability to cultivate strength within their teams.

This article argues, however, that in an environment where strength and toughness are highly valued, service members may feel compelled to suppress struggles with mental health, stress, or trauma as military guidance and instruction put forth an expectation of resilience. While resilience is a crucial trait in military culture, the pressure to always appear resilient can have unintended negative consequences. Additionally, this expectation may be based on conflicting science.

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20. Michael Ungar and Linda Theron, "Resilience and Mental Health: How Multisystemic Processes Contribute to Positive Outcomes," *The Lancet Psychiatry* 7, no. 5 (2020), https://www.thelancet.com/.

21. Ungar, "Social Ecology."

22. Department of the Air Force (DAF) Instruction 90-5001, *Integrated Resilience* (DAF, 23 July 2024), https://static.e-publishing.af.mil/.

23. *The Guardian Ideal* (US Space Force, 17 September 2021), 18, https://www.resilience.af.mil/.

24. M. J. Bates and S. V. Bowles, "Review of Well-being in the Context of Suicide Prevention and Resilience," *NATO Research and Technology Organisation Meeting Proceedings* RTO-MP-HFM-205 (2011), https://apps.dtic.mil/.

## The Science Is Not So Clear

Resilience has been studied and defined as being a trait, an outcome, or a process. Research has suggested that there are different pathways to growth following adversity. In 1996, scholars introduced the concept of posttraumatic growth (PTG) to describe the positive changes individuals experience as a result of struggling with highly challenging events or trauma.[25] They conceptualized trauma not only as a potential source of psychological harm but also a potential catalyst for meaning and transformation. Some of the significant changes associated with posttraumatic growth include discovering personal strength and improved relationships characterized by deeper connections and empathy.[26] Posttraumatic growth has also been associated with a reevaluation of priorities and meaning in life; spiritual growth, including a stronger sense of purpose and existential insights; and a newfound appreciation of life, with heightened awareness of life's everyday joys.[27]

Over the past two decades, there has been a growing body of research on the concept of resilience, accompanied by some confusion.[28] There is no uniform or widely accepted definition of resiliency, and its theoretical foundation remains controversial.[29] Is resilience a characteristic or personal quality, a process, or an outcome?[30] Other scholars argue that resilience is not an individual trait but rather a dynamic process involving interactions between the individual and their environment.[31] Critics highlight issues such as ambiguous

25. R. G. Tedeschi and L. G. Calhoun, "The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma," *Journal of Traumatic Stress* 9, no. 3 (1996), https://doi.org/.

26. P. Alex Linley and Stephen Joseph, "Positive Change Following Trauma and Adversity: A Review," *Journal of Traumatic Stress* 17, no. 1 (2005), https://doi.org/; C. L. Park and J. R. Fenster, "Stress-Related Growth: Predictors Of Occurrence and Correlates with Psychological Adjustment," *Journal of Social and Clinical Psychology* 23, no. 2 (2004), https://psycnet.apa.org/; R. G. Tedeschi and L. G. Calhoun, "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," *Psychological Inquiry* 15, no. 1 (2004), https://www.jstor.org/; and Xuan Wang et al., "Social Support, Posttraumatic Growth, and Prosocial Behaviors Among Adolescents Following a Flood: The Mediating Roles of Belief in a Just World and Empathy," *Current Psychology* 42 (2022), https://doi.org/.

27. Tedeschi and Calhoun, "Posttraumatic Growth"; Kelli N. Triplett et al., "Posttraumatic Growth, Meaning in Life, and Life Satisfaction in Response to Trauma," *Psychological Trauma: Theory, Research, Practice, and Policy* 4, no. 4 (2012), https://doi.org/; Park and Fenster, "Stress-Related Growth"; and Annick Shaw, Stephen Joseph, and P. Alex Linley, "Religion, Spirituality, and Posttraumatic Growth: A Systematic Review," *Mental Health, Religion & Culture* 8, no. 1 (2025), https://doi.org/.

28. K. Kolar, "Resilience: Revisiting the Concept and its Utility for Social Research," *International Journal of Mental Health and Addiction* 9, no. 4 (2011), https://doi.org/.

29. Kolar; and Suniya S. Luthar, Dante Cicchetti, and Bronwyn Becker, "The Construct of Resilience: A Critical Evaluation and Guidelines for Future Work," *Child Development* 71, no. 3 (2003), https://doi.org/.

30. Nancy R. Ahern, Pamela Ark, and Jacqueline Byers, "Resilience and Coping Strategies in Adolescents," *Pediatric Nursing* 20 (2008), https://doi.org/.

31. M. Rutter, "Resilience, Competence, and Coping," *Child Abuse and Neglect* 31, no. 3 (2007), https://psycnet.apa.org/; and S. Masten and M. O. Wright, "Resilience over the Lifespan: Developmental Perspectives on Resistance, Recovery, and Transformation," in *Handbook of Adult Resilience*, ed. J. W. Reich, A. J. Zautra, and J. S. Hall (The Guilford Press, 2010).

definitions, heterogeneity in experiences of individuals identified as resilient, and concerns about the usefulness of resilience as a theoretical construct.[32]

Additionally, many existing theories on PTG and resilience have received modest empirical investigation, and many suffer from a lack of credibility and reliability.[33] The research on posttraumatic growth often asks individuals to estimate how much they have changed in the positive as a result of their trauma. Yet retrospective self-reports of growth are frequently inaccurate, as individuals struggle to accurately recall what they were like before the traumatic event.[34] Further, participants are asked to attribute their perceived changes solely to the adverse life event. This involves complex mental processes, which can impact accuracy.[35] Personality psychologists have shown that actual pre-post change is often weakly correlated with individuals' self-perceptions of change over time.[36] Additionally, researchers have found that some individuals report personal growth when they are, in reality, struggling.[37] Discrepancies also arise when comparing self-reports of PTG with assessments from friends and family, which often do not align, raising questions about the validity and meaning of self-reported growth after trauma.[38] While change occurs after experiencing a traumatic event, it is not always quantifiable as growth.[39] This highlights the need for more nuanced and objective measures of posttraumatic change.

## Case Studies

Another reason to question the empirical support for posttraumatic growth and resilience is that many studies have shown that when adversity strikes, people do not change significantly

32. Luthar, Cicchetti, and Becker, "Construct of Resilience."

33. Jaye Wald et al., *Literature Review of Concepts: Psychological Resiliency* (Defence R & D Canada – Toronto, 2006), https://apps.dtic.mil/; and Eranda Jayawickreme and Frank J. Infurna, "Toward a More Credible Understanding of Post-Traumatic Growth," *Journal of Personality* 89, no. 1 (2021), https://doi.org/.

34. Meghan Owenz and Blaine J. Fowers, "Perceived Post-Traumatic Growth May Not Reflect Actual Positive Change: A Short-Term Prospective Study of Relationship Dissolution," *Journal of Social and Personal Relationships* 36, no. 10 (2018), https://doi.org/.

35. J. D. Ford, H. Tennen, and D. Albert, "A Contrarian View of Growth Following Adversity," in *Trauma, Recovery, and Growth: Positive Psychological Perspectives on Posttraumatic Stress*, ed. S. Joseph and P. A. Linley (John Wiley, 2008).

36. J. H. Herbst et al., "Self-perceptions of Stability and Change in Personality at Midlife: The UNC Alumni Heart Study," *Assessment* 7, no. 4 (2000), https://doi.org/; and Richard W. Robins et al., "Do People Know How Their Personality Has Changed? Correlates of Perceived and Actual Personality Change in Young Adulthood," *Journal of Personality* 73, no. 2 (2005), https://doi.org/.

37. Iris M. Engelhard, Miriam J. J. Lommen, and Marit Sijbrandij, "Changing for Better or Worse? Posttraumatic Growth Reported by Soldiers Deployed to Iraq," *Clinical Psychological Science* 3, no. 5 (2014), https://doi.org/.

38. Vicki S. Helgeson, "Corroboration of Growth Following Breast Cancer: Ten Years Later," *Journal of Social and Clinical Psychology* 29, no. 5 (2010), https://doi.org/.

39. Patricia Frazier et al., "Does Self-Reported Posttraumatic Growth Reflect Genuine Positive Change?," *Psychological Science* 20, no. 7 (2009), https://doi.org/.

over time, or they may experience increased adversity as time progresses.[40] Additionally, some research suggests that PTG, or the expectation of growth after trauma, might have effects contrary to the positive outcomes often highlighted, challenging the optimistic narrative promoted by other studies.

A seminal 2009 study of 1,500 undergraduate students over eight weeks examined the experiences of 122 students who reported a traumatic event that caused high levels of distress. These students completed the standard posttraumatic growth inventory used to measure PTG.[41] The study found that students who perceived growth were associated with increased distress from pre- to post-trauma. Moreover, perceived growth was not correlated with measures of actual growth or improvements in well-being.

A seven-year longitudinal study of 84 breast cancer survivors in Taiwan found that those who engaged in an illusory PTG coping process exhibited more anxiety and depressive symptoms, greater hopelessness/helplessness coping, and more anxious/preoccupation coping compared to those with constructive PTG.[42] Constructive PTG reflects a realistic adaptation process that acknowledges the changes and impact of trauma; whereas, illusory PTG involves attempting to maintain psychological equilibrium through self-deceptive perceptions of positive changes. In other words, individuals with illusory PTG may act as if everything is fine, denying or suppressing their negative emotions while reporting perceived positive growth, which is associated with harmful long-term outcomes.

A longitudinal study specific to the military involved 479 Royal Netherlands Army infantry soldiers and assessed them four months before deploying to Iraq and again five months and 15 months post-deployment.[43] Soldiers who reported greater perceived growth from their experiences in Iraq at five months post-deployment exhibited more posttraumatic stress symptoms at 15 months post-deployment.

The implications of this last study are important, particularly because it occurs among military members. The tendency to emphasize the importance of self-growth in response to traumatic events may actually be counterproductive to a military member's well-being, leading to more harm than good. In this case certainly, what does not kill an individual does not necessarily make them stronger. In fact, the pressure to be stronger may be what actually kills.

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40. Edward B. Davis et al., "Religious Meaning Making and Attachment in a Disaster Context: A Longitudinal Qualitative Study of Flood Survivors," *Psychological Trauma: Theory, Research, Practice, and Policy* 14, no. 5 (2019), https://doi.org/; Robert Joseph Ursano and James Ray Rundell, "The Prisoner of War," *Military Medicine* 155, no. 4 (1990), https://doi.org/; Cristina A. Fernandez et al., "Assessing the Relationship Between Psychosocial Stressors and Psychiatric Resilience Among Chilean Disaster Survivors," *The British Journal of Psychiatry* 217, no. 5 (2020), https://doi.org/; and Andrew Rakhshani and R. Michael Furr, "The Reciprocal Impacts of Adversity and Personality Traits: A Prospective Longitudinal Study of Growth, Change, and the Power of Personality," *Journal of Personality* 89, no. 1 (2021), https://doi.org/.

41. Frazier et al., "Self-Reported."

42. Chih-Tao Cheng, Ging-Long Wang, and Samuel M. Y. Ho, "The Relationship Between Types of Posttraumatic Growth and Prospective Psychological Adjustment in Women with Breast Cancer: A Follow-up Study," *Psycho-Oncology* 29, no. 3 (2020), https://doi.org/.

43. Engelhard, Lommen, and Sijbrandij, "Changing."

## Posttraumatic Growth: A Cautionary Tale

Author and minister Norman Vincent Peale once stated that the reason why the world is full of problems is to help individuals grow strong enough to handle even greater challenges. He explained that the only way to make a man strong is through resistance, struggle, pain, frustration, and disappointment.[44] This "strong man trope" is prevalent in Euro-American culture and psychological research. Messages of posttraumatic growth and resilience often reinforce this narrative of triumphing over adversity. This is also true in military war stories or portraits of military heroes. While many individuals who experience genuine change after trauma tend to have better quality mental health outcomes, research suggests that merely perceiving change or faking it after an adverse event can lead to higher levels of mental distress.[45]

The idea that people who experience trauma will ultimately benefit from it is compelling and is often promoted as a pathway to recovery. It suggests that suffering is necessary to become the best version of oneself. Some may argue that this model gives people hope and inspiration. Others question if it demands that people who are suffering not only have to survive the trauma but also must show evidence that they have come out stronger on the other side.[46] This pressure may interfere with an individual's efforts to seek help when they are not coping well or when they are losing hope.

Aligned with this idea, studies have found that self-reports of posttraumatic growth are often associated with avoidance coping, which involves engaging in behaviors such as procrastination to avoid stressors; denial coping, which entails refusing to accept the reality of a situation; and negative religious coping, which generally involves some struggle or conflict with finding meaning in life or with the idea of the divine.[47] Additionally, PTG does not relate to forgiveness of self, forgiveness or others, or self-efficacy, but it is related to less psychological closure of the event.[48] The expectation of resilience after trauma may pressure those who are struggling to conceal their difficulties out of fear of being perceived as weak, broken, or lacking resilience.

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44. Norman Vicent Peale, *The Power of Positive Thinking: A Practical Guide for Mastering the Problems of Everyday Living* (Touchstone, 1952).

45. Frazier et al., "Self-Reported."

46. Shankar Vedantam, host, *Hidden Brain*, podcast, "Healing 2.0: What We Gain from Pain," 6 November 2023, https://hiddenbrain.org/.

47. Adriel Boals and Keke L. Schuler, "Reducing Reports of Illusory Posttraumatic Growth: A Revised Version of the Stress-Related Growth Scale (SRGS-R)," *Psychological Trauma: Theory, Research, Practice, and Policy* 10, no. 2 (2018), https://doi.org/; M. M. Gerber, A. Boals, and D. Schuettler, "The Unique Contributions of Positive and Negative Religious Coping to Posttraumatic Growth and PTSD," *Psychology of Religion and Spirituality* 3, no. 4 (2011), https://doi.org/; and Charlotte Henson, Didier Truchot, and Amy Canevello, "What Promotes Post-Traumatic Growth? A Systematic Review," *European Journal of Trauma & Dissociation* 5, no. 2 (2021), https://doi.org/.

48. Darnell Schuettler and Adriel Boals, "The Path to Posttraumatic Growth Versus Posttraumatic Stress Disorder: Contributions of Event Centrality and Coping," *Journal of Loss and Trauma* 16, no. 2 (2011), https://doi.org/.

## Fixing the Growth Illusion

The expectation of growth after suffering can intensify the burden for those already struggling. Trauma and suffering do not always result in growth, and when they do, the process rarely follows a predictable or linear path.[49] The pressure to appear "okay" or to demonstrate progress can exacerbate mental health challenges, increase suicidal thoughts, and diminish hope. Promoting the idea of growth after trauma may also compel individuals to claim growth they have not experienced, out of fear of being perceived as broken or ungrateful. Perpetuating the belief that trauma should leave one stronger or unchanged risks deepening pain and fostering isolation.

Imagine a service member grappling with the adverse effects of deployment. He struggles with sleep and appetite, finds it difficult to concentrate at work, and faces instability in his personal relationships. He has attended resilience training and internalized the message that hardship builds strength and "iron sharpens iron."[50] Yet, as he observes others in his unit appearing to cope well, he begins to question himself. If resilience is expected, why is he struggling? He may start to believe that something is inherently wrong with him, that he is weak. This sense of inadequacy may lead him to withdraw, reluctant to admit his struggles for fear of being seen as lacking the strength to be resilient. After all, hard times are supposed to make him stronger. Yet, the emotional, cognitive, and social distress he experiences, combined with the pressure to grow from trauma, can deepen his isolation, a key risk factor for poor mental health outcomes and an increased risk of death by suicide.

DOD guidance on service member readiness and suicide prevention emphasizes fostering resilience to support the overall well-being of military personnel. While acknowledging the complexity of resilience, such guidance often adheres to the notion that trauma and suffering inherently lead to greater strength. A glance at the stories of resilience on the Air Force's Integrated Resilience website reveals the hero's journey narrative frequently applied to service members.[51] While hope and the belief that resilience is possible are crucial, resilience is not simply about bouncing forward. It requires recognition of the challenges that come before growth can occur.

In stories and movies, the hero does not instantly move from the challenge to growth. The plot in the middle makes the story, and this is the reality for humans. Without the details of the struggle it is not a believable journey. A more nuanced approach to resilience must account for the struggles that precede recovery, rather than assuming strength is the inevitable, required outcome of hardship.

An alternative approach to the expectation of growth after trauma is to focus on the reality of cognitive and emotional responses to adversity.[52] Instead of hoping for or expecting growth after disruption, acknowledging the pain and confusion of disruption

49. Jayawickreme and Infurna, "Post-Traumatic Growth."
50. Prov. 27:17, New International Version.
51. DAF Integrated Resilience (website), accessed 12 March 2025, https://www.resilience.af.mil/.
52. Jayawickreme and Infurna, "Post-Traumatic Growth."

is both more realistic and more humane. Trauma from certain tragedies, such as the death of a child or spouse or the realities of war, may never fully fade nor help bring about greater strength in an individual, and this is not a sign of weakness but a reflection of the human condition.

For some, simply returning to their pre-trauma state or having the will to live with the new posttraumatic state may be an aspirational goal. Normalizing the profound emotional and psychological pain of trauma may do more to support recovery than promoting expectations of growth. Recognizing that trauma challenges personal values, religious beliefs, emotional regulation, and persistent ruminations can help survivors understand that their responses are typical and valid. This understanding may also increase the willingness to seek help, especially when living for the future with their new reality seems hopeless.

Rather than emphasizing messages like "this is an opportunity to learn," survivors might benefit more from reassurances such as "the pain you feel makes sense," "others experience this, too," and "what you're going through is understandable." These supportive messages can help individuals focus on their immediate needs and priorities, reducing the tendency to isolate themselves in their suffering or the shame of not growing from the pain. A military culture of resilience may reinforce messages that struggling makes one stronger, but resilience is not simply enduring hardship. Overemphasizing self-reliance and underemphasizing emotional struggles may cause service members to suppress distress, fearing that admitting difficulties is a sign of weakness rather than part of the resilience process.

The service member in the above scenario recalls only part of the biblical proverb, "As iron sharpens iron." The other half, "so one person sharpens another," underscores the importance of community and mutual support in fostering strength.[53] Importantly, this message affirms that humans are inherently vulnerable and require connection with others to thrive; they are not meant to cope and grow in isolation. Military leaders, caregivers, and helping agencies are key in this process toward resiliency. Research suggests that resilience is not simply about enduring hardship but also about facing disruptions, reflecting on them, and integrating them into one's life narrative.[54] Such findings indicate that this process has a more profound impact on long-term well-being and agency than the expectation of resilience alone. By accepting life's changes, including trauma, individuals can develop a sense of agency that enables them to preserve hope for a life worth living. ✈

53. Prov. 27:17.

54. Nic M. Weststrate and Judith Glück, "Hard-earned Wisdom: Exploratory Processing of Difficult Life Experience Is Positively Associated with Wisdom," *Developmental Psychology* 53, no. 4 (2017), https://doi.org/.

# Resources

If you or someone you know needs assistance, contact:

### 988 Suicide & Crisis Lifeline

https://988lifeline.org/
24/7 confidential hotline for people in suicidal crisis or emotional distress

- Call or Text 988 or chat online

### The Military Crisis Line

www.veteranscrisisline.net/get-help/military-crisis-line/
24/7 confidential resource for all service members, including veterans and members of the National Guard and Reserve, even if not enrolled in Veterans Affairs benefits or healthcare

- Dial 988, Press 1 or text 838255
- Chat Online
- If you have hearing loss, call TTY: 800-799-4889
- For active-duty personnel outside of NORTHCOM, call:

| EUCOM | PACOM | CENTCOM | AFRICOM | SOUTHCOM |
|---|---|---|---|---|
| 1-844-702-5495 (off base) or DSN 988 | 1-844-702-5493 (off base) or DSN 988 | 1-855-422-7719 (off base) or DSN 988 | 1-888-482-6054 (off base) or DSN 988 | 1-866-989-9599 (off base) or DSN 988 |

### National Alliance on Mental Illness (NAMI)

https://www.nami.org/
Grassroots organization dedicated to building better lives for Americans affected by mental illness

- Call 800-950-NAMI (6264)
- Text or Chat "helpline" to 62640 (M-F, 1000–2200 EST) Text or Chat 988 (24/7)

### Tragedy Assistance Program for Survivors (TAPS)

https://www.taps.org/
National nonprofit organization providing compassionate care and comprehensive resources to all those grieving a death in the military or veteran community

- Call 24/7 helpline at 1-800-959-TAPS (8277)

### American Association of Suicidology (AAS)

www.suicidology.org/, for clinical survivors

### Coalition of Clinician-Survivors (CCS)

https://www.cliniciansurvivor.org/

### American Foundation for Suicide Prevention (AFSP)

https://afsp.org/ or call 888-333-2377

### Suicide Prevention Resource Center (SPRC)

https://www.sprc.org/

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