SOCIOLOGY OF KNOWLEDGE

MILITARY SUICIDE

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DEDICATION

To strong women with conviction, direction and knowledge. At times I may struggle, look for answers—yet I know you all are with me, watching over and guiding me through life. Your collective presence has always been my strength and my sense of pride. I love and miss you all—Trinidad Virgil, Lillian Brown and Dolores Winn.

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ABSTRACT

This study examines the United States Army and the bureaucracy involved as they address their most recent increase in suicide. Suicide is not a new problem in the military, but increased numbers have caused significant concern at all levels, which have extended to those outside the military as well. This report is one of *Sociology of Knowledge* in that I attempted to understand how the United States Army is processing and understanding themselves while addressing an increase in suicide deaths. Utilizing publicly available data to conduct a secondary analysis, this study specifically examined a 2010 report release from the Army which looked at Health Promotion, Risk Reduction and Suicide Prevention. This study is not a comparison study between the various branches of the armed services; nor does it attempt to explain the "why" associated with the rise in suicide rates. Instead this study looked at how a tightly-integrated formal organization, such as the United States Army, cognitively and bureaucratically developed an understanding of suicide.

Theoretical perspectives associated with labeling theory, deviance, as well as race and gender helped to frame this study. These concepts were also used to develop coding

practices and conclusions and recommendations based on the Army 2010 Army report. This study was aimed at identifying the effectiveness of findings and interpreting the Army's effort at understanding itself. This study is particularly timely since suicide rates in the Army continue to increase—but conclusive answers to this intolerable trend have yet to be uncovered.

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Without question my family means the world to me. Always there, interested and listening to my thoughts and ideas. Sometimes I may have been over the top but you all still showed your faith and conviction in me. I love you all!

True friends are few and far between. I wish I could name you all, but I hope you know who you are! Please know that your friendship, concern, belief and confidence in me were always on-time and encouraging and I love and thank you all.

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Finally to Mr. Jim Chiles – wonderful man and an intellectual beyond, your words and teachings stay with me daily – I love you, I miss you and I feel your pride. I only wish you were here as it all comes to an end.

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CHAPTER 1.

INTRODUCTION AND CONCEPTUALIZATION

French sociologist, Emile Durkheim (1859-1917), is perhaps best known for his 1897 case study of suicide, a phenomenon that he defined in the following way: "the term applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (Pickering and Walford; 2000). A number of decades later, Clinard and Meier (1975) defined the term as "the destruction of oneself – self-killing or self-murder in the legal sense" (p. 497). More recently, Retterstol (1993) described suicide in somewhat more detail: "An act with a fatal outcome that is deliberately initiated and performed by the deceased him or herself, in the knowledge or expectation of its fatal outcome, the outcome being considered by the actor as instrumental in bringing about desired changes in consciousness and/or social conditions." Although these definitions are similar in that they describe an irreversible and tragic outcome, they do not begin to explain the complex motivations that would lead an individual to take her or his life.

Suicide is many things to different people: tragic, shocking, horrifying, enraging, mysterious, a relief, a shame, a stigma, a shattering legacy, a cry for help, a release from pain, selfish, heroic, insane, a way out, the right choice, the last word, punishment, revenge, a protest, a weapon, a political statement, tempting, desperate, upsetting, unsettling, a mistake, angry, hurtful, dramatic, a cop-out, devastating and unforgivable

(Marcus, 1996). What reinforces the alarming nature of suicide is that it is currently categorized as the second and third leading cause of death (depending on specific age groups) in the United States according to the CDC's (Center for Disease Control) National Vital Statistics System. Highly relevant to the current study is the fact that over the past several years the United States military has reported the highest number of suicides in decades—and more specifically, the highest numbers in the U.S. Army.

Suicide: Worldwide and National Rates

In 2009, the World Health Organization (WHO)[1] reported that worldwide approximately one million people took their own lives, which means that about 10.7 people per 100,000 committed suicide. In terms of frequency, every 40 seconds somebody dies worldwide from a suicide.[2] An additional alarming fact is that suicide rates have increased from 5% to 62% over the past decade.[3] In 2009, WHO assessed the world's incidence of suicide and subsequently produced a suicide map of the world, which is shown in Figure 1. Although the map's legend shows three frequency categories, the WHO also listed suicide rates by countries, and these are categorized by four levels: high, medium high, medium, and low (Table 1).

[1] WHO, which was established in 1948 and is a specialized agency of the United Nations, is dedicated to bringing people to their highest possible level of health through expert assessments of global health topics, advanced health research and reliable published statistics.

[2] http://safetynethospital.blogspot.com/2010/05/via-medical-billing-and-coding.html.

[3] Unless otherwise noted, the suicide rates included in this study are based on 100,000 individuals.

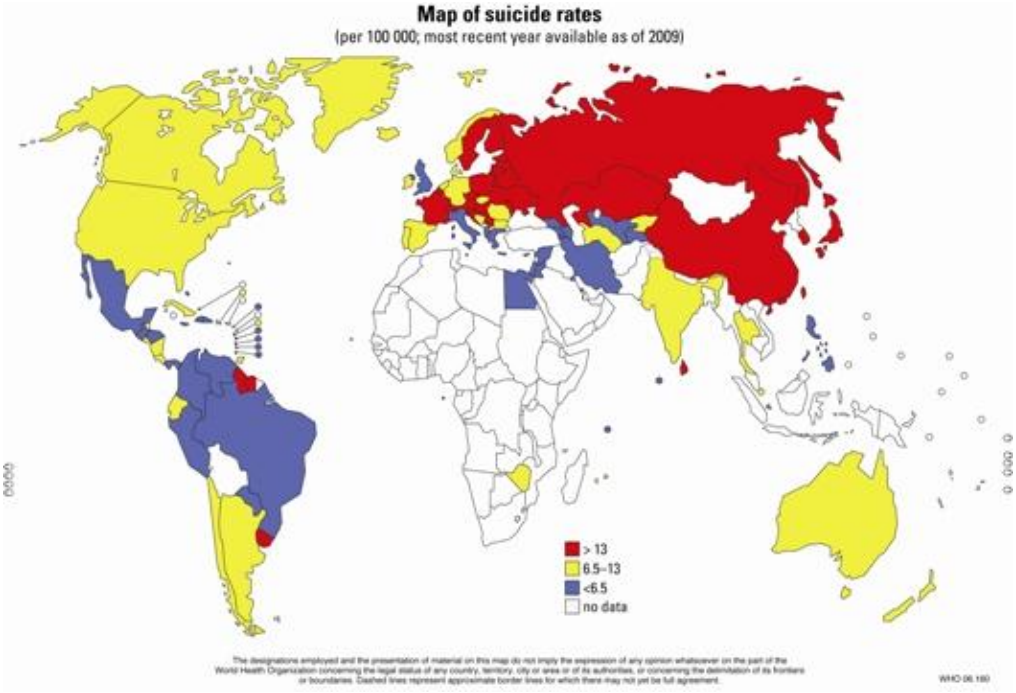

Figure 1. World Health Organization suicide map for 2009

Table 1. Various Suicide Rates Per Country (per 100,000)

High		Medium High		Medium		Low	
Lithuania	42	Japan	23.8	China	13.9	Spain	8.2
Russia	38	Belgium	21	Denmark	13.6	Italy	7.1
Belarus	35	Finland	20	Germany	13.5	UK	6.9
Kazakhstan	28	Switzerland	18	Sweden	13.4	Israel	6.3
Ukraine	26	Austria	18	Australia	12.7	Argentina	6.4
		S. Korea	17.9	Canada	11.9	Brazil	4.1
		France	17.6	India	10.7	Thailand	4.0
		S. Africa	15.4	U.S.	11.0	Iran	2.0
				Singapore	9.5	Kuwait	2.0
						Egypt/Jordan	ZERO

Adapted from the WHO (2009)

The WHO also provides data on worldwide suicide frequency according to sex (Table 2). What is significant about this data is that of the 104 countries shown below, only one—China—has a higher female suicide rate than among males; even then the difference is relatively slight. Overwhelmingly, worldwide suicide data indicate that males take their lives with greater frequency than do females. It should be noted, however, that in the case of the U.S., even though males take their own lives at nearly four times the rate of females and represent over 78% of all U.S. suicides, American women *attempt* suicide two to three times more often than men (CDC, 2010).

Table 2. Rates Per 100,000 By country/Year and Sex*

Country	Year	Males	Females
Albania	03	4.7	3.3
Antigua And Barbuda	95	0.0	0.0
Argentina	05	12.7	3.4
Armenia	06	3.9	1.0
Australia	04	16.7	4.4
Austria	07	23.8	7.4
Azerbaijan	07	1.0	0.3
Bahamas	02	1.9	0.0
Bahrain	88	4.9	0.5
Barbados	01	1.4	0.0
Belarus	03	63.3	10.3
Belgium	99	27.2	9.5
Belize	01	13.4	1.6
Bosnia And Herzegovina	91	20.3	3.3
Brazil	05	7.3	1.9
Bulgaria	04	19.7	6.7
Canada	04	17.3	5.4
Chile	05	17.4	3.4
CHINA (Selected Rural & Urban Areas)	*99*	*13.0*	*14.8*
China (Hong Kong Sar)	06	19.3	11.5
Colombia	05	7.8	2.1

Country	Year	Males	Females
Costa Rica	06	13.2	2.5
Croatia	06	26.9	9.7
Cuba	06	19.6	4.9
Cyprus	06	3.2	1.8
Czech Republic	07	22.7	4.3
Denmark	06	17.5	6.4
Dominican Republic	04	2.6	0.6
Ecuador	06	9.1	4.5
Egypt	87	0.1	0.0
El Salvador	06	10.2	3.7
Estonia	05	35.5	7.3
Finland	07	28.9	9.0
France	06	25.5	9.0
Georgia	01	3.4	1.1
Germany	06	17.9	6.0
Greece	06	5.9	1.2
Grenada	05	9.8	1.9
Guatemala	06	3.6	1.1
Guyana	05	33.8	11.6
Haiti	03	0.0	0.0
Honduras	78	0.0	0.0
Hungary	05	42.3	11.2
Iceland	07	18.9	4.6
India	98	12.2	9.1
Iran	91	0.3	0.1
Ireland	07	17.4	3.8
Israel	05	8.7	3.3
Italy	06	9.9	2.8
Jamaica	90	0.3	0.0
Japan	07	35.8	13.7
Jordan	79	0.0	0.0
Kazakhstan	07	46.2	9.0
Kuwait	02	2.5	1.4
Kyrgyzstan	06	14.4	3.7
Latvia	07	34.1	7.7
Lithuania	07	53.9	9.8

Country	Year	Males	Females
Luxembourg	05	17.7	4.3
Maldives	05	0.7	0.0
Malta	07	12.3	0.5
Mauritius	07	16.0	4.8
Mexico	06	6.8	1.3
Netherlands	07	11.6	5.0
New Zealand	05	18.9	6.3
Nicaragua	05	11.1	3.3
Norway	06	16.8	6.0
Panama	06	10.4	0.8
Paraguay	04	5.5	2.7
Peru	00	1.1	0.6
Philippines	93	2.5	1.7
Poland	06	26.8	4.4
Portugal	04	17.9	5.5
Puerto Rico	05	13.2	2.0
Republic Of Korea	06	29.6	14.1
Republic Of Moldova	07	28.0	4.3
Romania	07	18.9	4.0
Russian Federation	06	53.9	9.5
Saint Kitts And Nevis	95	0.0	0.0
Saint Lucia	02	10.4	5.0
Saint Vincent And The Grenadines	04	7.3	0.0
Sao Tome And Principe	87	0.0	1.8
Serbia	06	28.4	11.1
Seychelles	87	9.1	0.0
Singapore	06	12.9	7.7
Slovakia	05	22.3	3.4
Slovenia	07	33.7	9.7
Spain	05	12.0	3.8
Sri Lanka	91	44.6	16.8
Suriname	05	23.9	4.8
Sweden	06	18.1	8.3
Switzerland	06	23.5	11.7
Syrian Arab Republic	85	0.2	0.0
Tajikistan	01	2.9	2.3

Country	Year	Males	Females
Thailand	02	12.0	3.8
Tfyr Macedonia	03	9.5	4.0
Trinidad And Tobago	02	20.4	4.0
Turkmenistan	98	13.8	3.5
Ukraine	05	40.9	7.0
United Kingdom	07	10.1	2.8
United States Of America	*05*	*17.7*	*4.5*
Uruguay	04	26.0	6.3
Uzbekistan	05	7.0	2.3
Venezuela	05	6.1	1.4
Zimbabwe	90	10.6	5.2

Source: World Health Organization (WHO) Report.

*Suicide rates per 100,000 based on country year and sex. Earliest year identified is 1985; latest year 2007. Data collected is as current as year 2009.

The Centers for Disease Control (CDC) was a vital source of information with respect to suicide rates in the U.S. Although the agency was founded during WWII to deal with malaria, its outreach has expanded greatly and it is now "dedicated to protecting health and promoting quality of life through the prevention and control of disease, injury, and disability" (CDC, 2011, p. 1). The CDC's website also includes a significant examination of suicide (see http://www.cdc.gov/ViolencePrevention/suicide/index.html). The most recent CDC finding reported 11.26 suicides per 100,000[4] people in the U.S., accounting for 34,000 deaths. These translate to an astonishing 94 suicides per day, or one suicide about every 15 minutes. In findings similar to the 2009 WHO report, Jane Pearson (1995) also placed the U.S. in the middle with respect to

[4] CDC's suicide rates are based on 100,000 people. Reported data is based on 2007 numbers (unless specified otherwise); no CDC findings were available for post-2007 data.

suicide rates among industrialized nations. She reported that the age-adjusted suicide rate in the U.S. was 11.1 per 100,000.

In terms of geographic distribution in the U.S., a 2009 demographic map released by the CDC (Figure 2), which is based on death data from 2000 through 2006, indicates a higher prevalence of suicides in Northwestern and Middle Atlantic state regions, with Nevada having the highest suicide rate (23.93/100,000) and the District of Columbia the lowest (6.05/100,000) (Pearson, 1995).

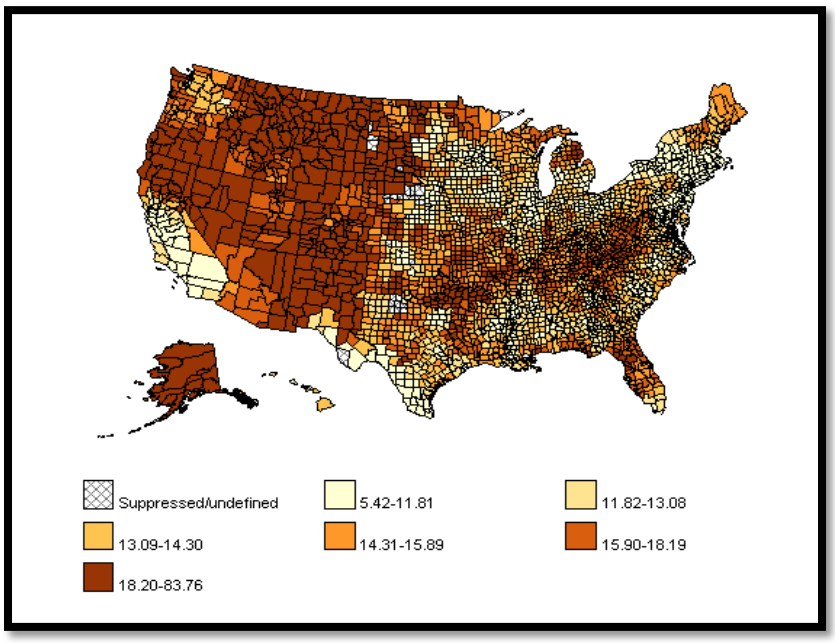

Figure 2. Age-Adjusted Suicide Rates* per 100,000 Population

All Races, All Ethnicities, Both Sexes, Ages 10 Years or Older, United States, 2000–2006 (from: http://www.cdc.gov/violenceprevention/suicide/statistics/suicide_map.html)

*All rates are age-adjusted to the standard 2000 population. Rates based on less than 20 deaths are statistically unreliable and are suppressed (see legend above). The age-adjusted rates have been geospatially smoothed to help reveal geographic patterns that would otherwise not be clearly visible.

In fact, according to 2008 statistics,[5] in Las Vegas the odds of dying by suicide are twice as high in comparison to the rest of the country—although according to sociology researcher Matt Wray (Nov 2008), this has nothing to do with the game industry.[6] Wray added that although residents of Las Vegas had a 50 percent higher risk of suicide than folks living elsewhere in the country, their suicide risk went down when they left the city.

Despite regional differences, nationwide suicide rates overall continue to be endemic—particularly among certain age groups. In 2010 one of the top three causes of death among young adults in the United States between the ages of 15-24 was suicide. Additionally, suicide is on the rise on college campuses across the United States (Szewcow, 2010). The CDC (2010) also reported that suicide rates for males are highest among those aged 75 and older (36.1/100,000), and for females the rates are highest among those aged 45-54 (8.8/100,000).

These global and national suicide statistics have hopefully provided a context for the main thrust of this dissertation—namely, the rise in suicides among military personnel (with a particular focus on the U.S. Army) and the efforts the service branches are taking to reduce these distressing statistics.

The Growing Problem of Suicide in the U.S. Military

In a timely reversal of protocol, President Obama announced on July 7, 2011, that he had reversed the policy that bars military authorities from sending official condolence

[5] http://www.lasvegassun.com/news/2008/nov/13/just-being-vegas-raises-risk-suicide-study-finds/

[6] Residents of Las Vegas had a 50 percent higher risk of suicide than folks living elsewhere in the country, their suicide risk when down when they left the city (Wray).

letters to the families of service members who commit suicide in a combat zone. This decision emerged as a result of steadily rising military suicide rates and a major Defense Department effort to turn the disturbing trend around. Despite the fact that the suicide rate among U.S. soldiers has historically been lower in comparison to the general civilian population, the U.S. Army reported that this statistic changed in 2008, and that it has grown increasingly lopsided ever since. As described by Tomasic (2011):

> Roughly 10 of every 100,000 people in the U.S. commit suicide each year. There are approximately 550,000 active U.S. Army personnel and last year 156 of those soldiers killed themselves. Even allowing for fluctuating active duty numbers, that's more than double the civilian suicide rate—and that's merely counting active Army soldiers. The rate of suicide among National Guard and Army reservists nearly doubled last year to 145. In the Navy, suicide is now the third highest cause of death. Given the fact that the country is engaged in two wars, it startles to learn that more U.S. service members killed themselves last year than died in combat. It's a problem the military is determined to address, even though some lawmakers appear not to want to acknowledge there's any problem at all. (Tomasic, 2011, para. 4)

No one knows exactly why there has been such a dramatic rise in the number of military suicides since 2008—or if a single cause could ever be identified given the long list of possible reasons: the past decade of military conflicts, medical issues resulting from war/combat, multiple tours of duty, types of recruits, relationship problems amongst soldiers and their families, the organizational structure and rules/regulations of the military, stresses associated with "Don't Ask/Don't Tell," as well as other factors not yet identified. Whatever the cause, suicide numbers have escalated to record highs despite service-wide efforts to turn this trend around. Between 2007 and 2008, suicide rates per 100,000 service members increased in every branch of the service, as follows: from 10 to 11.5 in the Air Force; 11.1 to 11.6 in the Navy; 16.5 to 19 in the Marine Corps, and from

16.8 to an estimated 20.2 in the U. S. Army.[7] Reinforcing Tomasic (2011), a 2009 Congressional Quarterly compilation reported that more U.S. military personnel took their own lives in 2009 than were killed in Afghanistan and Iraq.

Tragically, the rise in military suicides has not been limited to active-duty personnel. For example, during 2007 the suicide rate among veterans aged 20 to 24 was 22.9 per 100,000—four times higher than non-veterans in the same age bracket. Apparently, this statistic was so distasteful that in 2008 the U.S. Department of Veterans Affairs (VA) concealed veteran suicide statistics and fed the news organizations faulty data for a story on this problem.[8] A 2011 report from the California Veterans Association (CA-VA) stated that every day 18 veterans commit suicide—meaning that 120 veterans are taking their own lives every week. This statistic does not take into account those who attempted suicide and did not succeed. As reported by Maze (2010):

> Troubling new data show there are an average of 950 suicide attempts each month by veterans who are receiving some type of treatment from the Veterans Affairs Department. Seven percent of the attempts are successful, and 11 percent of those who don't succeed on the first attempt try again within nine months. (Maze, 2010, para. 1-2).

The CA-VA report (2011) also confirmed that the suicide rate among all veterans was at least three times the national suicide rate, and that the suicide rate for veterans aged 18-24 was three to four times higher compared to non-veterans (2005 data). Overall, as of May 2011, one of every five suicides in the nation was a veteran—a statistic that has become utterly unacceptable for the military.

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[7] *Air Force Times* Magazine Feb 2009; identified suicide statistics for all branches of the military.

[8] From article "More U.S. Veterans Die Due to Suicide than in Combat" Posted: 2011/05/23.

Suicide in the U.S. Army

Because this study focused on the U.S. Army, it was important to review suicide trends within this particular branch of the U.S. military. Up to 2004, Army suicide rates were significantly lower compared to the general civilian population. That rate gradually increased after 2004, and as of 2010 there were 301 suicides among active Army soldiers (includes Army reservists). In other words, approximately 25 soldiers a month were taking their own lives. Over the past five years, a total of 975 U.S. Army soldiers have died as a result of suicide (Jan. 2011).[9]

As suicides continued to rise, the Army took action. Early in 2009, the Army established a Suicide Prevention Task Force (SPTF) headed by the Vice Chief Secretary of the Army (VCSA)—a move that represented the Army's determination to confront this issue from the top. The task force also consisted of a select group of military professionals and a range of civilian personnel from professional organizations. The Task Force's purpose was to rapidly analyze and assess the problem, evaluate existing programs intended to lower the suicide rate, and make urgent and lasting changes in the way the Army approached health promotion, risk reduction and suicide prevention amongst soldiers. The Army defined *health promotion* as any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental changes conducive to the health and well-being of the Army community. *Risk reduction* was linked with the ways commanders/leaders intended to reduce high-risk behaviors among their soldiers. The Army defined suicide

[9] http://www.aolnews.com/2011/01/20/army-reserve-national-guard-suicides-doubled-in-2010.

prevention as an urgent, multi-layered objective that would require a holistic approach—which they labeled their Campaign Plan. This was a comprehensive plan that mandated unprecedented changes in Army doctrine, policy and resource allocation, with the goal of providing immediate guidance to Army leadership to help address the problem of suicide. The Campaign Plan was the result of a joint decision by the Secretary of the Army and the Army Chief of Staff to hand the responsibility of overseeing the comprehensive integration of the Army's efforts to prevent suicides over to the VCSA, which amongst other efforts developed the Suicide Prevention Task Force.

Important to the current study, the VCSA also produced a report in July 2010 that addressed those three Army goals: health promotion, risk reduction and suicide prevention amongst soldiers. This document, described by the Army as a "complex report addressing a complex subject [which] was once considered a private affair or family matter [but] now threatens the Army's readiness" (VCSA, 2010, p. 1), reflected a year's worth of work at the direction of Army senior leadership in order to provide a "directed telescope" on increasingly alarming suicide rates. The nine-section report features an overview of the problem, conclusions, and recommendations—all of which are documented by vignettes, quotes, figures, tables and tutorials. As will be discussed in greater detail, from a sociological perspective the report seems to lack certain nuances that might have more effectively addressed suicide amongst soldiers.

Purpose of the Study

The purpose of this study, which conceptualizes suicide as a social problem worthy of sociological inquiry, was to explore the U.S. Army and understand suicide

amongst soldiers. It includes an appraisal of the July 2010 report of the initial findings of the Army Suicide Prevention Task Force and assesses the Army's goal of reducing the unacceptable rates of suicide among active-duty and veteran personnel. As discussed earlier, the impetus for the Army's efforts came from a significant six-year consecutive rise in suicides, among soldiers which was above the national average and reached a record high of 20.2 per 100,000[10] over this period. It should be noted that the focus of the current study was on one aspect of the Army' effort to reduce suicide rates amongst soldiers through specific attempts to understand its causes. The perspective I have taken here essentially addresses the sociology of knowledge. In other words, I have attempted to interpret the Army's efforts to reduce suicide in terms of the process the Army took to understand itself. Additionally, I endeavored to interpret those efforts as an outcome of an ongoing social process that would shed some light on and reveal certain facts about U.S. society, the Army, and explanations for suicide.

This study focused specifically on the problem of suicide in the U.S. Army and does not include a comparative study of suicide in other service branches. Although important, this study also did not attempt to explain all the possible explanations for the increase in the numbers of suicides in the U.S. Army. Instead, I sought to address how a tightly-integrated formal organization—namely, the U.S. Army—cognitively and bureaucratically developed a better understanding of suicide amongst its personnel so that it could tackle the problem more effectively.

[10] Numbers from the 2010 Task Force Report, Page 13; Jul 2010.

Definition of Concepts

Bureaucracy

Drawing from Max Weber (Ritzer & Goodman, 2004), *bureaucracy* is defined as "a form of an organization of rational-legal authority . . . characterized as a continuous organization bound by rules; in a specific area of competence and hierarchy" (p. 214). Weber described the ideal typical bureaucracy as "capable of attaining the highest degree of efficiency, and is in this sense formally the most rational known means of exercising authority over human beings; that it is superior to any form in precision, in stability, in the stringency of its discipline and in its reliability (p. 214). Weber also described how various emerging technologies within the military necessitate the growth of military bureaucracies. As such, the U.S. Army could be viewed as an epitome of bureaucratic organization bound by rules, specific competencies, and hierarchical order—which is typical of other military institutions as well. And according to Karl Marx[11] institutions serve to maintain the power of the dominant class. George Mead (1934) later described an institution as a complex system of beliefs and practices that help to shape an individual's attitudes and roles within it. Mead went on to describe how an individual must negotiate a number of institutions, often balancing the competing demands of each. Weber, however, conceded that although institutions are interdependent, he did not believe that there was a single institution that determined the rest. In *Professional Soldier*, Morris Janowitz (1960) wrote about the basic conflict between the traditional solidarity of a community and rational integration within that community and how they

[11] http://en.wikipedia.org/wiki/Marxist

both relate to bureaucracy and professionalism. Ervin Goffman (Smith, 2006) developed the term "total institution" and defined it as "a place of residence and work, where a large number of similar people live, cut off from the wider society for an appreciable period of time" (p.71). Goffman added that such an institution is typically characterized "by the walls and barriers which surround it" (p.71) and is populated by people for whom the institution is everything; it fixates every part of their life. Goffman's (Smith, 2006) description of a total institution in a modern society did identify separate spaces for sleep, work and play. Goffman broke down the barriers for each of these spaces and identified four common characteristics of a total institution: (1) to be described as a routine set of activities that take place in the same place, under the same authority; (2) activities carried out in an institution under a batch of like situations; (3) activities timetabled and sequenced by clear rules and a class of officials; and (4) scheduled activities as part of a plan designed to realize the goals of the institution.

A vital component of the total institution is that it creates a division between those in charge (e.g., military officers/soldiers), accounting for what Goffman described (explained by Smith, 2006) as little mobility between the two and a considerable social distance. Goffman used the term "social cleavage" to describe this divide within institutions. In his 1985 treatise, "*The Soldier and the State,"* Huntington identified three forms of a national security policy—social, economic and political—and two levels involved in developing and carrying out these policies—operational and institutional. The operational level is needed to *meet* the security threat and the institutional level is responsible for the *execution* of the operational level. According to Huntington, a military

institution is shaped by two forces: (1) a functional imperative resulting from the threats to a society's security, and (2) a societal imperative arising from the social forces, ideologies, and institutions that Huntington believed was dominant within a society.

Labeling Theory

This study also used labeling theory in investigating the various social interactions and social structures present in the U.S. Army, which inevitably impact the suicide rate within this "total institution." Broadly speaking, labeling theory is concerned with how the *self-identity* and *behavior* of individuals may be determined or influenced by the terms used to describe or classify them; as such, it is associated with the concept of a *self-fulfilling prophecy* or *stereotyping.* Six decades ago, Charles Lemert (1951) introduced some key concepts in labeling theory, which were further developed by sociologist Howard Becker (1963) in his book, *Outsiders: Studies in the Sociology of Deviance*. Becker asserted that deviance was the creation of social groups, rather than the quality of a behavioral act and deviance is based on society as a whole. According to Becker, studying the act of the individual is unimportant because deviance merely represented rule-breaking behavior that is labeled deviant by persons in positions of power. Going back to the concept of stereotyping, labeling theory also suggests that once an individual feels a particular way, s/he will continue to behave in the manner society expects them to behave. Edwin Schur (1971) agreed with Becker in that deviance is based on society as a whole; however, Schur added that the focus of labeling theory is shifted to the individual deviant. In his *Labeling Deviant Behavior* (1971), Schur identified labeling theory as "human behavior deviant to the extent that it comes to be viewed as involving a

personally discreditable departure from a group's normative expectations *and* it *elicits* interpersonal or collective reactions that serve to 'isolate,' 'treat,' 'correct,' or 'punish' individual engaged in such behavior" (Schur, 1971, p. 24). Schur stated that if people who are labeled deviant can organize and gain power within the society, they will be able to change societal views on what is or what is not considered to be identified as deviant (1971). Schur defined the following concepts that are relevant to the current study:

Moral Entrepreneurship: Rules tend to be enforced only when something provokes enforcement, which then leads to someone taking initiative;

Retrospective Interpretation: Reactors begin to view deviators or suspected deviators in a totally new light*;*

Negotiation: The process of *negotiation* can be described as one's interpersonal reactions;

Stigma: The assignment of stigma to individuals and groups who engage in deviant behavior as a decidedly social process involving negotiation, bargaining, power and, at times resistance;

Organizational Processing: The idea that an organization can produce a deviant, but that not all deviants are the result of organizational influence;

Organizational Imperative: The idea that certain imperatives can help to promote or reinforce organizational behavior.

Race and Gender

Framed as socially-constructed interdependent power relations, race and gender are both social constructs with meanings that develop out of group struggles over

socially-valued resources. Although race and gender feature inherent biological referents, they are not necessarily fixed proprieties of individuals and their meaning can change over time depending on the social context (Weber, 2001).

Race

Weber (2001) linked one's race to ancestry, i.e., to selected physical characteristics such as skin color, hair texture and eye shape. In an expansion of this traditional definition, Michael Omi and Howard Winant (1986, 1994, 2009) viewed race not only as essential physical characteristics that categorize an individual with others that resemble him or her, but as something that is constantly undergoing negotiation and that is affected by everyday experiences, all of which will socialize the individual as to the meaning of their individual racial category. The authors also described race as a purely ideological construct that someone advocating an ideal, non-racist social order would eliminate. Omi and Winant (1986, 1994, 2009) argued that it is necessary to challenge both these positions in order to disrupt and reframe the rigid and bipolar manner in which the concept of race is defined and debated. Candace West and Sarah Fenstermaker (1995) in *Doing Gender* described how virtually any social activity within the United States presents the possibility of categorizing participants on the basis of race, adding that trying to establish race as a scientific concept has not been successful—for example, giving physicians the authority to assign race at the birth of a child.

Is race important? Race matters, according to philosopher Cornel West (1993), who argued that it is a constitutive element of life in America. West asserted that race is not just a set of physical characteristics, but rather a social structure constructed through

social interactions manifested in the institutions of society, interpersonal interactions, and the minds and identities of those living in a racially-based social order (Esther Ngang-ling Chow, Doris Wilkinson and Maxine Baca Zinn**,** 1996). In *Race, Class and Gender: Common Bonds, Common Voices,* Chow, Wilkinson and Zinn (1996) stated that race matters due to structure interactions, opportunities, consciousness, ideology and the forms of resistance that characterize American life.

Gender

Weber's (2001) description of gender identified certain biological and anatomical characteristics attributed to males and females, as well as culturally- and socially-structured relationships between women and men. Weber emphasized that like race, gender is constructed through the biological categories of men and women. Gender is a focused attention on men and women and the hierarchical relationship between them (Jackson and Scott 2000:9). African Americans are counseled to accept the complementary gender roles for men and women and to believe that although these roles may be more natural for African Americans to attain, gender roles are natural and normal (Collins; 2005: 183). Examining (Chow; 1996) how gender is accomplished could reveal the mechanism by which power is exercised and inequality is then produced.

Prior the term *gender*, Max Weber introduced the concept of patriarchy which sociologically legitimized the concept of "power" (Jackson and Scott 2000: 4). When the term *gender* was first conceptualized back in the late 1960 it was viewed as a social characteristic (description to include anatomical and physiological) and was later related in terms of biological sex. In order for gender to be addressed sociologically, there has to

first be an understanding of how gender and race interact together. This we see supported by Lynn Weber and Patricia Hill Collins throughout their works in terms of oppression. The Army as a structured institution is linked to race and gender and therefore *w*ithin this study they both are essential concepts as they relate to individuals and their decision to die as a result of a suicide.

Overview of Chapters

This study contains five chapters. Chapter 1 is the Introduction and Conceptualization. Chapter 2 contains the Literature Review and the theoretical framework for this study centered around the labeling theory, suicide, race/gender and findings within a 2010 U.S. Army report on suicide. Previous work and theoretical perspectives is also included. Chapter 3 outlines the research design; and a discussion of how the resulting data were used to address questions examined in this study as well as a discussion of the study‘s limitations. Chapter 4 contains findings based on The Bureaucratic Process of Making Sense of Suicide, while Chapter 5 contains findings based on Race and Gender in US Army Suicide Statistics. These two chapters (4 and 5) summarize, evaluate, and interpret the results in the context of the research question presented in Chapter 1. Finally, Chapter 6 concludes the study by discussing the findings as they relate to a) Labeling the Causes of Suicide, b) Suicide-Gender and Race Neutral or Specific, and c) Suggestions for Future Research.

CHAPTER 2.

LITERATURE REVIEW

In order to assess how the U.S. Army—a tightly-integrated formal organization both cognitively and bureaucratically—has attempted to develop a better understanding of the growing problem of suicide among its personnel, I approached this problem according to the following: (a) the theoretical framework for understanding suicide, (b) the nature of a military organization/institution (c) the relevant socio-historical context of suicide and the military (including the interface of suicide with race and gender), (d) the 2010 Army report on suicide, and (e) the overall significance of this type of examination.

Theoretical Framework

This overview of the relevant theoretical perspectives associated with this study is divided into two parts. Part I of this study explores the labeling theory of deviance in relation to how the Army "handles" suicide, while Part II first examines Army protocol in light of Emile Durkheim's classic sociological theory in his analysis of suicide; secondly suicide findings in relation to race and gender intersectionality, i.e., oppression based on the influences of marginalization of which include race and gender.

Part I: Labeling Theory of Deviance

As discussed in Chapter I, Schur's (1971) theoretical perspectives are based upon the labeling theory originally popularized by Becker (1963) and Lemert (1951). Much

earlier, however, Emile Durkheim suggested in his 1897 book, *Suicide*, that deviant labeling satisfies the need to categorize an act of outrage as something out of the norm, as well as satisfies society's need to control behavior. In applying this seminal definition of labeling theory to suicide, one must of course make some adjustments. First, society tends to view an individual who has committed suicide as being beyond punishment or correction. Thus, this research focused on the Army's attempts to "isolate," "treat," "correct" or "punish" individuals who seem to be on the brink of suicide, or work more generally with its personnel to recognize the warning signs for suicide. Second, western society tends to view suicide as being wrong in all cases—that no certain label can be attached to someone who takes his/her life. But the June 2011 death of euthanasia activist, Dr. Jack Kevorkian, has brought the issue of assisted suicide back to the forefront. In October of 1997 the state of Oregon enacted the Death with Dignity Act which allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. So if suicide is acceptable in certain case, why is the Army so concerned about soldier suicides? Again, the labeling theory suggests that once an individual feels a particular s/he will continue to behave in the manner society expects them to. How does this behavioral affect soldiers who resort to suicide? Does the Army label these acts by soldiers as deviant (i.e., in violation of social norms and institutionalized expectations), or does the structure of the military define it differently?

In reviewing Schur's definition of deviance, the degree of which human behavior comes to be viewed as deviant will depend in part on the ability of the viewer to establish

definition of the situation as the correct one—this ability is power (Brantley 1977), i.e., an Army officer meting out punishments has the *institutional force* of the military to support his judgments but, these judgments can of course be countermanded by a higher officer who has more power (Brantley: 1977; 73). Brantley also reminds us that the greater a person's capacity for power, the more likely the definition of the situation will prevail in the production of deviance outcomes.

The literature on deviance shows that power politics and the moral values of a particular social group play a significant role in identifying deviance…and that because of this the definition of deviance is different throughout society and can evolve over time. In her book, *The Politics of Deviance,* Anne Hendershott (2002) described how deviance has typically been defined by reason, common sense, social norms and a society's commitment to accept them—rather than emotion, political advocacy, or money. She argued that it is imperative to preserve definitions of deviance that rely on the moral ties that bind us together. Hendershott's views echo those of Durkheim, who identified deviance as an integral part of society, essential for affirming cultural norms and values. Durkheim maintained that deviance would always be a part of society at some level; his apparent homage to the criminal mind paved the way for later sociologists' focus on deviance and deviants (David Matza:2).

Part II: Suicide; and Race and Gender

Part II of my assessment of the theoretical underpinnings for this study encompassed two important perspectives: (1) a comparison of Emile Durkheim's (1897)

classic sociological analysis of suicide (*death resulting directly or indirectly from a positive or negative act of the victim himself)*; with the findings in this study, and (2) an analysis of race and gender; in-particular the intersectionality of race and gender, with the idea that every person embodies various vectors of oppression and/or privilege, with the most significant of these vectors identified as race and gender.

Suicide:

As discussed earlier, Emile Durkheim[12] was the first sociologist to introduce a plausible theory for suicide. His seminal work, *Suicide*, has been described as "one of the greatest pieces of sociological research conducted by anyone (Merton 1968:63), as "the cornerstone of the whole approach taken by most sociologists in the twentieth century," (Douglas 1967:xiii), and as "a monument" (Pope 1976:204). Durkheim tackled the subject of suicide as an example of how a sociologist could study such an extremely personal subject while at the same time introducing novel concepts that could be applied to understanding and explaining suicide. Durkheim's book, accomplished three objectives: (1) it identified the types of social causes associated with suicide; (2) showed how these causes produced effects; and (3) elucidated the relationship of social causes to the individual reactions associated with suicide. Specifically, Durkheim analyzed suicide rates and then through his analysis of social deviance, he categorized suicide into what he describes as the Four Fold classification of suicides, which consists of the following four

[12] A positivist who wanted to separate sociology from philosophy; he studied social facts which are social structures, norms and values to external and coercive to actors. Further discussion "The Plight of Service Sociology in America: Emile Durkheim and the US Army Suicide Study 2010" by J. Niebrugge-Brantley and C. Parris; submitted to Social Problems 2011.

terms: egoism, altruism, anomie, and fatalism—all said to be motivated by the "solidarity" experience—meaning that some suicides increase as people live and work in greater contact with one another.

Durkheim identified the key to each of these classifications as a social factor, consisting of a degree of social integration and/or regulation into society being either too high or too low:

Egoistic Suicide: Suicide that occurs where the degree of social integration is low, and there is a sense of meaningless among individuals.

Altruistic Suicide: Suicide that occurs when integration is too great, the collective consciousness too strong, and the "individual is forced into committing suicide."

Anomic Suicide: Anomie or anomy comes from the Greek meaning lawlessness—that is, a lack of law or norms. Anomy is social instability resulting from breakdown of standards and values.

Fatalistic Suicide: When regulation is too strong and the person's future is blocked; they see no way out. The individual sees no possible manner in which their lives can be improved, and when in a state of melancholy, may be subject to social currents of fatalistic suicide.

Within these four classifications Durkheim suggested that anomie, which stems from a mismatch between personal/group standards and wider social standards, represented an important cause for suicides (Giddens, 2009).

Durkheim suggested that all societies are predisposed to contribute a definite quota of voluntary deaths (*Suicide*, pp. 48 - 51). How does this voluntary death statement

then fit into the mission of the military and war in general? Durkheim's argument is that war, when balanced against his *social integration* analogy, indicates that because of the actual act of war and/or battles the military in general has less suicide. The question then becomes: is this analogy comparative dependent on the time, age or distinctiveness of the war or is it all wars in general?

Although it remains an essential reference for sociologists, scholars have been reanalyzing Durkheim's theories and applying them to more contemporary situations (Douglas, 1967; Atkinson, 1968; Besnard, 2002; Lemert, 2006). In fact, an increasing number of scholars have revealed ambiguities, conflicting interpretations and methodological shortcomings in Durkheim's methods (Pickering & Walford, 2000; Lester, 1994; Pescosolido & Georgianna, 1989; Stack, 1980; Pope, 1976; Douglas, 1967). Despite perceived problems in Durkheim's analysis of social conditions as described in *Suicide*, his study remains a solid foundation for studying the phenomenon of suicide in a postmodern society.

Race and Gender

Lynn Weber (2001:86) described *race* and *gender* as oppressed social systems that are complex, pervasive, variable, persistent, severe, and hierarchal. She also defined the two terms as social constructions constantly undergoing change at both the level of social institutions, as well as at the level of personal identity—which is true of all variables of oppression. As previously mentioned within this study Weber identified the interdependent power relations of race and gender as social constructs with meanings that

develop out of group struggles over socially-valued resources. In-turn, Patricia Hill Collins concept of intersectionality focuses on oppression, privilege, activism and agency and came about in response to Black women's ideas being suppressed by dominant groups. Intersectional paradigms remind us that oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice (Collins 2000: 18). Collins considers the interconnected oppressions of race and gender as a matrix of domination that allows dominant groups to exercise power and manipulate ideas of Black womanhood (Collins 2000: 68). Women of color, therefore, encounter a kind of double-whammy when it comes to systems of social impression that can impact family and work settings. As argued by Collins (2000), such women encounter oppressive experiences many times on a daily basis—but especially in the work environment. As women of color attain a certain status and move up the professional ladder, they not only have to deal with the intersection of race in the workplace, but oftentimes have this experience combined with the variable of gender. In a later examination of race and gender, Collins (2005) stated that the social construction of gender constitutes a distinct yet interconnected phenomenon, which in turn interconnects with race.

If one applies Collins' (2000) and Weber's (2001) interpretations of race and gender as systems of oppression to the U. S. Army, then it becomes clear that the Army is a *very* complex social system of oppression. In fact, Weber described military academies (e.g., West Point) as sites for the consolidation of ideological, political and economic power among privileged White, heterosexual men. While Weber, Collins, and others

continue to describe a link between gender and race based traditional definitions of the terms, Malik (1996) suggested that there are other ways to define race that go beyond basic biological indicators. He stated that society begins with a division of humanity into different races, which then finds a rationale in certain physical characteristics. Moreover, Malik asserted that what we constitute as "race" has changed dramatically over the past 200 years—and that this evolution ultimately ties any description of race into the needs of society at a given time. This line of thinking was also present by Johnson (2001:21).

For this study, it was important to use a race and gender perspective because it permits one to recognize and analyze the identities, perspectives, and relations (especially power relations) that are influenced by these two systems (Johnson, 2000). For example, gender identifies us as men and women situated within a social life that Johnson argued is based on different attitudes, forms of behavior, roles, and responsibilities.

Military Organizations/Institutions

Broadly speaking, institutions represent the customs and behavioral patterns that are important within a particular society. Because the U.S. Army represents an example of a "total institution" (Goffman, 1961)—namely, a place where a significant number of people are cut off from the larger community and lead a formally administered way of life—it has the potential to be extraordinarily influential.

Scott McNall (1973) described three fields of military sociology research: (1) those that see the military as one type of social organization that can be analyzed by traditional methods and/or models, (2) those that see the military and military behavior as

an anomaly that needs to be analyzed and explained, and (3) those that view the military as a major social institution that may independently influence other social institutions. In my view, the military is a major social institution because for good, bad or both the military shapes and/or impact the other institutional spheres of its members (i.e., family, social, recreational, economic, etc.).

As noted above, an essential component of a total institution (and thus the Army) is its influential structure. The Army is characterized by a highly stratified organizational structure, as exemplified by the fact that it is divided into squads, platoons, companies, battalions, brigades, divisions, and corps. Moreover, military literature is replete with various guidelines that soldiers, i.e., the rank and file must adhere to in order to become effective members and future leaders in the Army. Therefore, in order to effectively address the Army's suicide rate, it is important to fully understand the Army's organizational/institutional structure.

Organizationally, the Army is characterized by a complex chain of command based on the roles that individuals play within the Army—either routinely or according to mission-specific directives. According to documentation issued by the Army Reserve Officers' Training Corps (ROTC) in carrying out the mission of defending the nation, Army personnel—both soldiers and officers—must work as a closely-bonded team to execute complex tasks under sometimes difficult, dangerous conditions. If success in training and combat is to be achieved, a common culture is essential, which must include the following critical components:

- A system of rank reflecting a person's responsibilities and experience;
- An organizational structure in which people know their responsibilities;
- Military courtesies, customs, and traditions that serve to bond military professionals together.[13]

More than 40 years ago, Morris Janowitz, one of the foremost scholars in military sociology, wrote *The Professional Soldier*, in which he described a traditional military community as one marked by a high degree of cohesiveness (Segal, 1989). However, Janowitz also argued that military life was becoming impersonal, causing social relationships within military communities to change. He attributed this transformation, in part, to the technological advances that have reshaped the military's organizational authority and impacted the way military personnel interact. Janowitz added, however, that military communities have increasingly viewed social cohesion as a weakness—a weakness that could be part of the lack of interaction due to the technological advances. Also on the subject of technology, Weber asserted that the decline of personalized leadership has been necessary in order to help develop more complex technologies. According to David Segal (2000), organizational changes in the military are shaped by the military mission, which in turn has the potential to redefine a soldier's duties in unanticipated, and not necessarily satisfactory, ways.

The Department of Defense (DoD) oversees all military branches in the U.S. In *Professionals on the Front Line: Two Decades of the All-Volunteer Force* (Fredland,

[13] Army Rank, Structure, Duties and Traditions; ROTC.edu.

Gilroy, Little & Sellmam, 1996), we are reminded that the DoD is committed to providing a supportive environment for its service members, which includes a decent quality of life and a career advancement system that can ultimately lead to the military member either staying in the military, and/or becoming ambassadors for military service within their communities once they leave. According to Fredland, et al. (1996:260), whether or not the military reflects such societies depends on the *hierarchies of influence*, *economic well-being* and the *system for distributing resources*.

Socio-Historical Context of Suicide

Ever since Durkheim (1897) candidly addressed the subject of suicide more than a hundred years ago, theorists have attempted to explain the possible causes for such a drastic choice. As noted earlier in this chapter, a number of subsequent sociologists have challenged some of Durkheim's theories. For example, Douglas (1967) and Atkinson (1968) argued against Durkheim and his description of social facts—they felt he was mistaken. In other words, Durkheim's facts were part of the everyday social construction of reality, and as such were defined by the social actors at the time who described suicide. Douglas and Atkinson were not the only theorists who questioned Durkheim. Johnson (1965) and J. P. Gibbs (1968) claimed that Durkheim's only intent was to explain suicide sociologically from a holistic perspective. They asserted that Durkheim developed his theory in order to explain overall societal variations in the suicide rate—but he did not address the complex personal reasons why a person would take his/her own life. In addition to the four 60s-era "dissenters" named above, Bernard Berk (2006) also

questioned the micro-macro relationship of variables that Durkheim introduced. Berk observed that the variables Durkheim described within an individual are also the very same social forces that may be able to stop suicides. In another study that challenged Durkheim, Kusher and Kusher (1993) alleged that the earlier researcher's conceptualization of suicide and his interpretation of the data were framed by his own biases, as well as by those of his contemporaries.

According to Thomas Joiner, author of *Why People Die by Suicide* (2005), no persuasive theory on suicide has been published over the last two decades. As someone with personal experience with suicide (his father died of a self-inflicted puncture wound to the heart in August 1990), Joiner took it upon himself to provide a deeper understanding of suicidal behavior, including what was meant by the term suicide and if more deaths should be labeled as such. Through his research, Joiner proposed that there are three key motivational aspects that contribute to suicide: (1) a sense of being a burden to others, (2) a profound sense of loneliness, alienation and isolation, and (3) the absence of a fear of death or dying. Joiner argued that all three of these motivations or preconditions must be in place before someone will attempt suicide. Joiner's findings—coupled with those of Eric Marcus (1996) who in *Why Suicide* answered 200 of the most frequently asked questions about suicides—represent important contemporary and personalized assessments of suicide. In addition to addressing the "why" of suicidal behavior, Marcus (1996:117) also investigated the various emotional reactions experienced by those left behind, including shock, denial, guilt, blame, shame and anger—the same emotions reported by relatives and friends of Army suicides (Task

Force, 2010). However, Army survivors have emphasized feelings of guilt in relation to the suicide of their friend/relative, possibly in relation to not having tried to dissuade that individual (i.e., a son or daughter) from joining the military.

Military Service and Suicide

Although the literature has described links between military service and suicide over time, they do not always point to a higher incidence of suicide among active-duty service personnel or veterans. For example, Stack 2000c; Biro & Selakovic-Bursic, (1996) have reported a suicide *decrease* among wartime service personnel, including those who fought in World Wars I and II (Lester 2000). However, as documented by Carr (2004), research has shown that from 1998-1999 there were approximately 17% more suicides in all branches of the military among the "equivocal deaths" determined as either "accidental" or "undetermined." This same study showed that an additional 4% of these deaths were suspicious for suicide; this means that if reporting and classification methods are accurate, a rise of 21% in suicides in the military may be realistic. These percentage discrepancies point to an important problem—how to accurately classify an accidental or undermined death as suicide. And indeed, this misclassification of equivocal deaths is consistent with some civilian studies (Eaton, 2006) that report that as many as 38% of accidental or undetermined deaths may actually have resulted from suicide. [14]

[14] Also see Brent et al., 1987; Mohler & Earls, 2001; Phillips & Ruth, 1993; Rothberg & Jones, 1987; and Sentell et al., 1997. Additionally documented in 2010 Army Report.

Although the study was not intended to investigate the complex personal reasons why Army personnel have been taking their own lives in greater numbers, it is a critical topic that is worthy of additional study. Some of the reports investigated for the current study do include such information. For example, military leadership has suggested that there may be a link to substance abuse and soldier suicides. Similarly, an Army study showed that the percentage of soldiers in Afghanistan taking antidepressants and other mental-health drugs nearly tripled from 3.5% to 9.8% between their first and third deployments.[15]

Interface of Suicide with Race and Gender

The military is an institution characterized by social dynamics that differ from other large civilian organizations. When applying those dynamics to Lynn Weber's (2001) findings in terms of the variables of race and gender and the role they play in military suicides, those dynamics can be crucial. With respect to the field of suicidology, race has been the most understudied basic demographic variable (Lester, 1992; Stack, 1982). If race comparisons show significant discrepancies with respect to suicide—and in particular to dominant racial groups in the military—how would the Army use such data? Conversely, if race-based suicides are not shown to be more prevalent, how (if it all) is this addressed within the military? Weber (2001:87) asserted that race and gender are constantly undergoing changes within social institutions, and that these changes become deeply embedded in practices and beliefs. Thus, it is important to grasp the social

[15] Time Magazine "A Mounting Suicide Rate Prompts an Army Response," Dec 2009.

constructions of race and gender as they relate to suicide. How do they manifest themselves in terms of suicide both outside and inside the military?

As discussed earlier, all military branches are characterized by rules, regulations and authoritative structures. Domination and subordination, therefore, are inevitable and highly influential features of such an organization. We are reminded of Collins (2000:12) and her descriptions of how Black women in America are affected by the dual oppressions of race and gender—which the literature confirms are defining characteristics, even as an individual contemplates suicide. As for Ntozake Shange, argued in *For Colored Girls Who Have Considered Suicide, When the Rainbow is Enuf,* no matter how oppressed an individual woman might be, the power to save the self lies within the self (Hill: 2000:119).

Scholarly reports are incomplete when it comes to comparing African Americans (AA) and White Americans with respect to suicide. To date there are still relatively few multivariate studies in which AA and European American suicides are compared. Gibbs (1997) identified the patterns and trends of Black suicides across the lifespan, as well as the risk and protective factors in subgroups of Blacks. He reported that suicide in the African American community was traditionally lower compared to White communities, which he attributed in part to long- standing cultural values and beliefs that resist suicidal behavior as a problem-solving alternative. Additionally, Walker (2007) reported how various sociological scholars describe African Americans as having been described as "immunized" against suicide because it is a "White thing" and because families are protected against suicide (Early & Akers, 1993; Gibbs, 1988). dditionally, Early and

Akers (1993) suggested that these protective factors have social and cultural dimensions that counteract the effects of negative situations and a normative culture of values and beliefs that deter certain types of behavior, including suicide. Other findings, however, do not uphold Gibb's assertions. Despite speculation that suicide among African Americans is buffered by cultural beliefs, in reality the contemporary empirical literature that addresses African Americans' reluctance to choose suicide is limited. In fact, Michael Dyson (2004:334) reported that for Black men between ages of 18–29, suicide was the leading cause of death. He also argued that suicide in the Black community was on the rise, ranking as the third leading cause of death amongst Black men of all ages (Dyson: 2004:139). A recent report by The Surgeon General (2009) indicated that suicide rates among young Black men were as high as those of young White males[16]—in contrast to a report from the American Association of Suicidology that over a 12-year period Caucasian suicides were almost *twice* as high as African American suicides. Comparative suicide studies according to race are not limited to African Americans and Caucasians. Joiner (2005:160) maintained that Hispanics in the U.S. had the lowest suicide rate among the major races (5 per 100,000 people). This assertion conflicts with Willis (2003), who reported that although African Americans historically have registered lower rates of suicides than other ethnic groups, over the last 20 years this pattern has changed, particularly among young African Americans. A 1998 CDC study stated that younger African American males (under 35 years of age) were as likely to commit suicide as their

[16] U.S. Department of Health and Human Services, Office of the Surgeon General SAMHSA, 2009.

White counterparts; however, Willis argued that limited data were used to ascertain African American suicide risk factors, making the CDC findings suspect.

A number of scholars (Willis, 2003:412; Gibbs, 1997; Early & Akers., 1993) have discussed how African Americans tend to be socially integrated into their families (both immediate and extended), and that individuals who do become isolated from family ties lose a major source of social support that may be more important for maintaining mental health and coping mechanisms in comparison to Whites (Willis, 2003:412). Some reports (1999 Surgeon General Report; Early, 1993; Gibbs, 1988) have alluded to a protective factor when it comes to suicide in African American communities—namely the Black church, which purports suicide to be a highly condemned action. This protective factor dates as far back as findings discussed by Durkheim (1897).

With respect to other racial/gender-based studies of suicide in the U.S., Marcus (1996:20) reported the following statistics: Native Americans have the highest rate of suicide, followed by White Americans, Japanese Americans, Chinese Americans, Hispanics, African American and Filipino Americans. Further, where most findings identify a higher suicide rate among men, there is an exception in the case of China (see Table 2), where female suicides are slightly higher. One study (Yip et al., 2000) linked this finding to the fact that Chinese females in rural areas who commit suicide often use highly lethal methods (e.g., toxic agricultural poisons). Joiner (2005), however, disputed that finding and indicated that gender-based suicide rates in China are equal; he based this assertion on the fact that women in China are viewed as being inferior to men, which could translate to an under-reporting of suicide among women.

In most populations, however (especially in developed countries), males have higher completed suicide rates than females. Durkheim (1897) addressed this discrepancy and attributed it to greater social integration among women. Durkheim believed that women's gender roles in the family and community made them more immune to suicide than men. A century later, the assertion that gender roles or identity are considered to exert a major protective influence on suicidal behavior is supported by a number of researchers (Stack, 2000b; Hassan, 1995; Girard, 1993; Stack & Danigelis, 1985). With the possible exception of China, males also tend to use more lethal forms of suicide (Stack, 2000b; Hassan, 1995). Moreover, as reported by Lester (1997a), even when females use the same methods as males, they tend to be less successful at completing suicide. Gender-based suicide differences are also present in Army statistics, although distressingly, the number of female suicides is showing an increase. While 76,193 females account for a percentage of 13.5 (Oct 2010) Army wide[17]; recent findings from USA Today (Mar 2011) showed that the suicide rate increased from 5 per 100,000 to 15 per 100,000 among female soldiers at war. While a solid rationale for this finding has yet to be identified, scientists are looking into whether women feel isolated in a male-dominated war zone, or suffer greater anxieties about leaving behind children and other loved ones (Zoroya, 2011).

[17] http://www.womensmemorial.org/PDFs/StatsonWIM.pdf

Army Findings and the 2010 Report

The Army Health Promotion, Risk Reduction and Suicide Prevention report (July 2010) resulted from the work of the 2009-2010 Army Task Force. Figure 3, which depicts the most current available statistics on completed suicides (excluding the year 2003), indicates an upward swing in active duty suicide deaths beginning in the year 2004 (9.6) through year 2009 (21.8).

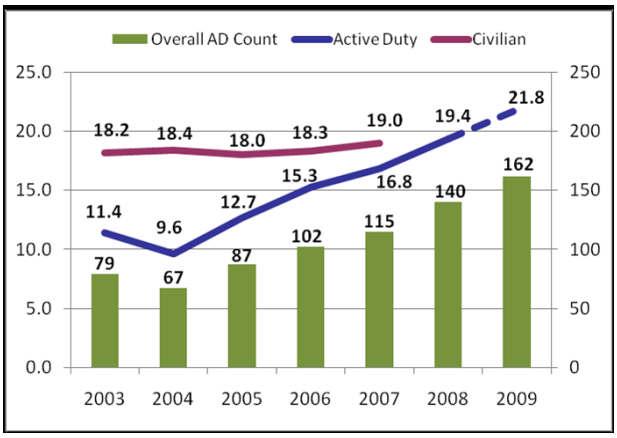

Figure 3. Active Duty Suicide Deaths; Report 2010

The Army Task Force studied existing policies and programs, and investigated a sizeable body of research about Army culture, probable causes for suicide, how suicide is affecting the Army, and other salient areas with the goal of reducing the incidence of suicide in its ranks. According to Task Force leadership involved in producing the report, it was meant to investigate the problem from the soldier's perspective in order to give immediate attention to the "high risk" or "at risk" solider. This highly-anticipated report garnered responses from a variety of professionals both inside and outside the Army:

> With suicides at an all-time high the Army released a report blaming "a permissive unit environment" for high risk behavior. The report cites an increase in waivers granted to new recruits coming into the Army. Since 2004 more than 20 percent of new recruits were granted waivers for behavior (drug, alcohol, misdemeanor crimes or serious misconduct) that otherwise would have kept them out of the service. Commanders may overlook misconduct when preparing their units for deployment to Iraq and Afghanistan because when you go to deploy you want every soldier you can get. *(Couric & CO report, 29 Jul 2010)*
>
> This report indicates no real conclusion as to why so many are taking their lives. The Army says that the horrors of war are not actually the cause for suicide. It's really not the Army's fault either. It has absolutely nothing to do with the stigma associated with asking for help. It isn't even because of the medications. It's simply that 1,713 people attempted suicide and 239 people successfully committed suicide and the report suggests that these 1,952 people had other reasons for taking their lives or attempting to do so, and thus the blame game begins again. *(Army Serves Us a Clandestine Report on Suicide)*
>
> The report released by the Army's Suicide Prevention Task Force is entitled, "Health Promotion, Risk Reduction, and Suicide Prevention." Why is suicide being lumped in with high risk behaviors such as drug abuse, drunk driving, and law breaking? According to the report in 29% of army suicides drugs or alcohol is a factor. That means in 71% of them drugs or alcohol is not. The report also states that 60% of suicides are first-term soldiers. These first-term soldiers are men and women who volunteered to serve because they wanted to make the world a safer place only to experience NCO supported gladiator fighting or "Self-absorbed pricks who make a fit about nothing…"[18]

At the conclusion of the Army study, leadership found/acknowledged gaps blaming the Army's transformation and a decade of war.[19] What follows are key findings from the report:

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[18] U.S. Department of Defense; Army Releases Suicide Report, Prevention Recommendations; 29 Jul 2010.

[19] Task Force Report, Introduction to Health Promotion, Risk Reduction, Suicide Prevention; p. 1.

- ✓ Gaps in the policies, processes and programs necessary to mitigate high risk behaviors;
- ✓ Erosion of adherence to existing Army policies and standards;
- ✓ Increase in indicators of high risk behavior (drug use, other crimes/suicide attempts);
- ✓ Lapses in surveillance and detection of high risk behavior;
- ✓ Increased use of prescription antidepressants, amphetamines and narcotics;
- ✓ Degraded accountability of disciplinary, administrative and reporting processes;
- ✓ Continued high rate of suicides, high-risk related deaths and other adverse outcomes.

Based on the findings of the 2010 report, the Vice Chief Secretary of the Army stated that there were no universal solutions to address the complexities of personal, social and behavioral health issues that lead to suicide.[20] However, as a result of the 2010 report, the Army authorized the formation of a second Task Force (2010-2011), as well as identified over 400 additional tasks to be addressed by them.

Summary/Significance of the Study

Clearly, suicide is not a new problem in the U.S. military or among the civilian population. In response, researchers have addressed various aspects of it here and elsewhere for quite some time. For example, Cogan (2009) and Parker, Cantrell, et al.

[20] Defense Talk; Global Defense and Military Portal, 30 Jul 2010.

(1997) studied ethnic patterns of suicide over an individual's life cycle. Lester (1987, 1992 and 1994) studied the tragedy and impact of suicide overall, suicides in prison, as well as suicides in Turkey; Thompson (2004) investigated suicide research and African Americans; Warshauer and Monk (1978) looked into suicide disparities between Blacks and Whites; Sher and Vilens (2010) developed 13 essays that addressed the relationship between military service and suicidal behavior; and Pernin, Ramchand, Acosta and Burns (2011) reported on suicide prevention in the military. Although these various scholars addressed particular aspects of suicide/suicidal behavior, they all agree that such an act can lead to devastating results for the victim and his/her family and friends. Losing someone to suicide is not only personally painful, but can impact those left behind in extraordinary and long-term ways (e.g., economic) (Joiner, 2005). As this chapter has documented, the U.S. Army is losing more soldiers to suicide than to the current war in Afghanistan[21]—a statistic that is totally unacceptable by anyone's standard. The military's effort to reduce suicides and suicidal risk is a continual process spearheaded by a team of individuals combating this effort on a daily basis. It is imperative that all members of the military, but particularly those with policy/programmatic responsibilities, are armed with awareness and trained to develop and administer effective prevention measures that help soldiers manage the various stresses associated with a military lifestyle. Thus, a study that addresses the sociological impact of how the Army develops a greater understanding of suicide—and how it does that while identifying the various

[21] Article, Suicide and the Military, AMY MENNA, PH.D., LMHC, CAP

underlying "considerations" associated with this issue, may add a different perspective that could help address this problem more effectively.

Additionally, data pertaining to suicide must be reported accurately since it plays an essential role in addressing the magnitude of the problem. Reliable not only affects the way Army suicides are reported, but also affects the "end strength" of the Army's total number. This ultimately influences all military branches since the military is *collectively* confronted by the increased number of suicides.

The Army Health Promotion, Risk Reduction and Suicide Prevention findings were released in their July 2010 report. This document is the first of its kind to set a goal for understanding and reducing the unfortunate rise in the occurrence of suicide. However, from a sociological perspective, there were problem areas that the Army did not address. This study, therefore, was intended to fill those gaps. To reiterate, I have attempted to interpret the Army's efforts to reduce suicide in terms of the process the Army took to understand itself. Additionally, I endeavored to interpret those efforts as an outcome of an ongoing social process that would shed some light on and reveal certain facts about U.S. society, the Army, and explanations for suicide.

CHAPTER 3.

METHODOLOGY

The primary objective of this study was to explore how the United States Army addresses suicide, which is conceptualized as a social problem worthy of sociological inquiry. As well documented in the literature, the Army is a large institution governed by various rules, regulations and processes that are meant to address a wide variety of circumstances and constituencies—including how suicide is dealt with at all levels of the organization. Using published data from the 2010 Army Health Promotion and Risk Reduction report (in addition to other secondary data sources, detailed herein), this study represents an in-depth examination and assessment of the escalation in suicides in the US Army, and how the organization is responding to the problem. Labeling theory and related concepts essential to the methodology were used to carry out the study. For example, as discussed by Bailey (2007), an important construct of this study involved an examination of status characteristics—and especially gender and race—since they structure nearly every aspect of everyday life.

Data Analysis Method

Using available data from the 2010 Army Health Promotion and Risk Reduction report, this study used a qualitative method of content/document analysis employing secondary data. Content analysis is a qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies

and meanings (Patton, 2002). In order to narrow the focus of research, which had the potential to head in many different directions, I concentrated on analyzing documents that had some relevance to evaluation mechanisms and program development.

The importance of the qualitative portion of this research is that qualitative methods focus on understanding the world in which one lives (and for this study, dies), interpreting it as much as possible from the participant's frame of reference, while at the same time accounting for experiential circumstances and emotional responses (Williams, 2003). As described by Babbie (2002), using secondary data analysis involves employing data that was previously collected by another researcher(s), typically for another purpose. Nonetheless, Babbie asserted that the use of secondary data analysis has become an important research tool with a number of inherent advantages: (1) it is less expensive and less time consuming to use data already available; (2) there are fewer human subject concerns (if any) since such issues were presumably addressed during the original data collection, (3) it is useful for accessing information on hard-to-identify populations, (4) it is effective for monitoring trends over time, and (5) it is unobtrusive. At the same time, however, Babbie reminded us that when it comes to qualitative data processing there are no cut-and-dried steps that guarantee success. He described qualitative data analysis as both an art and a science that involves the following key tools: *coding* (classifying or categorizing individual pieces of data, which can then be coded into groupings); *memoing,* which refers to writing notes to oneself and other researchers to describes the coding, sorting, and integrating process; and *concept mapping,* which involves putting concepts in a graphical format and then using diagrams to explore relationships within

the data. This method allowed me to complete the analysis without involving clients or interrupting regular program operations.

Given the nature of this study and the sensitive climate surrounding the issue of Army suicides, using a qualitative method helped to keep certain parameters in mind in attempting to understand how the Army has responded to the growing incidence of suicide among its ranks. Nonetheless, it should be stressed that this was not a study about the *number* of suicides. I relied on publicly available data from a report released in 2010 by the Army, as well as secondary data retrieved from the Centers for Disease Control (CDC) and the World Health Organization (WHO). I also employed other public statistics and findings that the Army has made available over the past several years, and these data sources are detailed below.

Data Sources

2010 Army Report – Health Promotion and Risk Reduction Report

Just last year, the US Army published a report on "Health Promotion and Risk Reduction" among its personnel. This report represents a holistic approach to the escalating rise in the number of suicides. As documented in Figure 1, the incidence of Army suicides has been climbing since 2004, but experienced an alarming rise beginning in 2007. When the 2007-08 numbers were released, Army leadership assembled a task force consisting of a wide range of individuals—including active Army personnel, National Guard members, Army reservists, civilian experts in suicide, and Army contractors. In essence, the Army engaged in what amounted to a large and applied

sociological field study of suicide in its attempt to understand the problem from all angles.

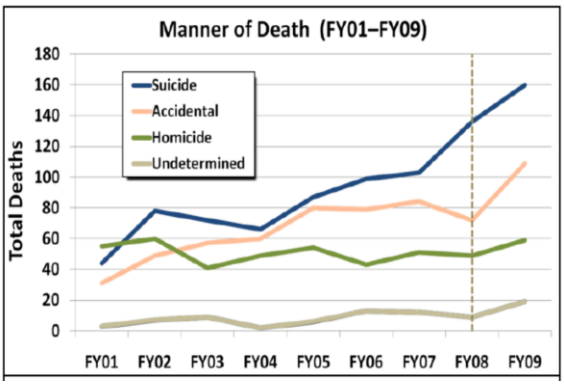

Figure 4: Manner of Death Chart from 2010 Army Report

The task force established a specific protocol for collecting data on Army suicides and used the data collected as the basis for their analyses. To ensure accuracy, the Army conducted extensive statistical reviews of available pertinent suicide data so that it could be used effectively in analyzing the problem and suggesting intervention. Given the sensitive nature of the topic, researchers attempted to keep in mind the human element associated with available statistics—namely that human preconceptions and perspectives inevitably featured into data content. To account for bias, the Army employed a myriad of sources when it came to reporting confirmed suicides, which researchers considered essential throughout the collection protocol.

As noted within the report, the document *reflects a year's worth of work at the direction of the Army's Senior Leadership to provide a "directed telescope" on the alarming rate of suicides in the Army; it represents both initial findings of the Army Suicide Prevention Task Force and informs the future of Suicide Prevention within the*

Army (2010 Report:1). The tables and figures included in the report were either assembled specifically for this report and/or garnered from other sources that authors identified. In total, the report contained 78 figures, 67 recommendation and conclusions, 29 tables and 29 quotes identified and/or referenced throughout. The authors also included 37 vignettes which they identified as real-world stories that could substantiate the report's findings.

Centers for Disease Control (CDC)

The CDC is responsible for collecting, analyzing and publishing fatality statistics in the United States using the National Vital Statistics System, which includes information on suicides. According to the CDC website, their purpose is as follows:

> To work 24/7 keeping America safe from health, safety and security threats, both foreign and domestic. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights it and supports communities and citizens to prevent it. CDC is the nation's health protection agency—saving lives, protecting people from health threats, and saving money through prevention.[22]

The CDC not only keeps track of disease trends and prevention tactics, but they also track the incidence of suicide and work toward its prevention. The CDC categorized suicide as follows:

> A serious public health problem that can have lasting harmful effects on individuals, families, and communities. While its causes are complex and determined by multiple factors, the goal of suicide prevention is simple: Reduce factors that increase risk (i.e. risk factors) and increase factors that promote resilience (i.e. protective factors). Ideally, prevention addresses all levels of influence: individual, relationship, community, and societal. Effective

[22] http://www.cdc.gov/ViolencePrevention/suicide/index.html

> prevention strategies are needed to promote awareness of suicide and encourage a commitment to social change.[23]

The CDC addresses all aspects of suicide from a public health perspective, which includes a variety of statistics, facts, and prevention methods. For example, the CDC uses a manual system to input information on an individual's reported death. CDC data can be used by public health officials, researchers, practitioners and the public to better understand the burden of suicide, population subgroups at risk, and the need for effective prevention efforts. Additionally, the CDC web pages provide an overview of suicide trends and patterns in the United States, and presents suicide data at the national level to users. The data sources that CDC uses when addressing suicides are as follows: Hospital Inpatient Discharge Data, National Electronic Injury Surveillance System, National Hospital Ambulatory Medical Care Survey, and the National Violent Death Reporting System. The data used from the CDC was used to identify general findings with respect to US suicide statistics, but also a national breakdown between race and gender.

It should be noted, however, that CDC data criterion does not always dovetail with how the Army records and reports their organization-specific data. This discrepancy is reflective in the CDC data used in this study; specifically, the CDC data is from 2008—in contrast to the Army, which has reported public data as current as 2011. For this study, I used the 2008 CDC and Army data, but have at times referenced current (post-2008) Army statistics. In addition, the "capital per number" figure used is 1 per 100,000 per people. A portion of the data reviewed for this study used the CDC's most current numbers as a baseline; however, I also employed findings released within the

[23] http://www.cdc.gov/

2010 report which used 2009 figures. In order to access and analyze racial and gender composition, I studied the breakdown from the CDC's most current findings (i.e., from 2008).

The World Health Organization (WHO)

The WHO is the directing and coordinating authority for health within the United Nations system. It is an organization responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends. As shown on their website,[24] the WHO describes information and data collection *the ongoing systematic collection, analysis, and interpretation of health data necessary for designing, implementing, and evaluating public health prevention programs*. According to the organization, in order to develop effective prevention strategies, countries need to improve their information reserves. In particular, countries need to know about the numbers and types of injuries that occur and about the circumstances in which those injuries occur. Such information will indicate how serious the injury problem is, and where prevention measures are most urgently needed.

The WHO Statistical Information System (WHOSIS) has been incorporated into the Global Health Observatory (GHO) to provide the user with more data, more tools, more analyses and more reports. WHOSIS is intended to guide to health and health-related epidemiological and statistical information available from the World Health

[24] http://www.who.int/violence_injury_prevention/surveillance/en/

Organization. The WHO mortality database, global burden of disease database and global alcohol database may be accessed from this site. The data from this report was used to identify WORLDWIDE suicide statistics, and then compare them on a country-by-country basis to the United States.

Army Reports and Sources

My document analysis included analyzing reports used by the Army, as well as identifying the sources used in determining a soldier's death as a suicide. The resulting information helped to make sense of the bureaucratic process involved in labeling and addressing suicide. Specifically, I used the 2010 DoDSER[25] (Department of Defense Suicide Event Report), which is a document that was developed and is used by all branches of the military. This report covers every aspect of objective and subjective information as it pertains to risk behavior, including suicide. I then reviewed the four agencies/individuals directly involved in the notification and confirmation of a soldier's death: the United States Army Criminal Investigative Division (CID), the Armed Forces Medical Examiner (AFME), the soldier's Commander,[26] and a Commander at the Medical Treatment Facility (MTF). My evaluation of these documents also analyzed and captured statistics as they related to race, gender and the Army.

[25] DoDSER released August 2011.

[26] Person in charge of soldiers. The term "commander" is officially applied to the commanding officer of army units; hence, there are company commanders, battalion commanders, brigade commanders, and so forth

Method

To determine my findings, I reviewed the Army 2010 report, in addition to other documents that either supplemented or deviated from the Army's current methods for addressing suicide escalation in its ranks. As noted earlier, using a qualitative method that employed secondary data analysis allowed me to complete the analysis without involving clients or interrupting regular program operations—both of which were essential in such a high-level/stress environment. When analyzing such diverse sources I employed the labeling process as captured by Schur (1971). This method interpreted the data described in Chapter 4 of my study and related it to Schur's labeling theory—a theory introduced and discussed in Chapters 1 and 2. My method involved applying organizational processing, organizational imperatives, retrospective interpretation, moral entrepreneurship, and stigma labeling as they individually or specifically related to the analysis and labeling of the Army as a bureaucratic institution. Further, by reviewing the Army results in terms of any race and gender statistics, the goal was to identify the factors and effects found when it came to suicide that these variables showed in the general non-military population.

The Army 2010 report captured data and anecdotal evidence from March 2009 through June 2010 pertaining to suicide, which resulted in statistical and informational conclusions. Overall, the report identified 67 recommendations and conclusions. It is important to note, however, that each chapter and section(s) within each chapter captured a number of subject-specific recommendations and conclusions. The report then labeled each set of conclusions and recommendations as appropriate to a particular section of the report. Once I reviewed and analyzed each of the combined recommendations and

conclusions, I then coded them based on assigned discussions within each chapter, as shown in Table 3. Using the Army definitions of the combined conclusions and recommendations, I coded the results into the following five categories:

1. At risk (ATRISK): Soldiers who senior leaders identify as those who engage in high risk behavior long before their deaths;
2. Bureaucracy (BUREA): An organization bound by rules, specific competencies, and hierarchical order;
3. Medical Behavior (MEDBH): Medical/behavioral from a health perspective, which further identifies the contribution of the cultural, operational, geographical and social environments that are unique to soldiers and families;
4. Transitions (TRANS): Soldiers and families feeling the strain and stress of nine years of conflict in Iraq and Afghanistan, and the cumulative effect of transitions of institutional *requirements*, along with family expectations/obligations, compounded by deployments;
5. Other (OTHER): Any conclusions and recommendations that identify definitions and structural pieces for the Army.

From the 67 total conclusions and recommended actions identified, over a third suggested continuing a bureaucratic approach in the future as the Army continues to address suicide—and the enhanced role bureaucracy may play. The document analysis in this study helped not only to gain an insight into the Army's suicide program, but also helped elucidate patterns that might be missed as a result of how such a large institution

is organized. While examining for trends, patterns, and other consistencies within the document, aspects of the Army suicide program itself was also evaluated.

Table 3. Coding System

Numerical Breakdown of Conclusions and Recommendations	Major Categories*	Specific Conclusions and Recommendations
6; 9; 17; 52	ATRISK	Awareness of Risk Factors; Leading a High Risk Population; Creating and Sustaining a High Risk Population; Current Reality of the High Risk Population; Investigating and Reporting High Risk Behavior In Non-Fatal Cases
12, 16; 18 -19; 21-22; 26; 27-29; 31-32; 41-43; 45- 49; 50; 51; 53; 56; 58	BUREA	Commanders, Law Enforcement, and Surveillance Program; Required Actions in Response to Illegal Activity; Disciplinary Infractions and Crimes; Soldiers with Two, and Three (or More) Felonies; Sexual Offenses; Death Cases; the Composite Life Cycle; Unit Life Cycle Strand Model; Soldier Life Cycle; Family Life Cycle; the Composite Life Cycle; Summary of the Composite Life Cycle; Potential CE and Cross-Enterprise Impact On HP/RR/SP Governance; Commanders' Roles and Responsibilities; Alignment of Proponents; Program Governance for HP/RR/SP; the Potential HP/RR/SP Program Portfolio; Core Enterprises, and Action Agents; Introduction to Program Management; the Interim HP/RR/SP Program Portfolio; Validating the HP/RR/SP Program Portfolio; Continuous Process Improvement; Balancing the Operating and Generating Force for HP/RR/SP; Investigating Non-Combat Soldier Deaths; Obstacles to Information Sharing; Transformation of Research Governance, Structure and Process

Table 3, continued

Numerical Breakdown of Conclusions and Recommendations	Major Categories	Specific Conclusions and Recommendations
5; 7- 8; 13-15; 20; 23-24; 40	MEDBH	Stigma; Medical Issues; Primary Care as Initial Behavioral Health Screen; Drug and Alcohol Detection; ASAP Drug Testing Program; Reporting Criminal Behavior Including Drug and Alcohol Incidents; Soldiers with Multiple Positive Drug Tests; Prescription Drug Referrals; Soldiers with Multiple And Serial Positives; The Event Cycle & Care Continuum
59, 60 - 67	RSCH	Mat The Recruit Phase; Research For The Separate Phase; Research For The Awareness/Resiliency Phase; Research for the Assess Phase; Research for the Educate/Train Phase; Research for the Intervene Phase; Research for the Treat Phase; Research for the Inquiry Phase
25; 30; 44	TRANS	Transitions, Major Life Events and Stress; Impact of Transitions on Soldiers & Families; Garrisons Sustaining And ASCC/COMPO Exporting
1-4	OTHER	Example of Conclusions & Recommended Actions; Introduction to the Reality of Suicide; Suicide Statistics; Suicide Factors and Demographics

*ATRISK = At Risk Soldiers; BUREA = Bureaucracy; MEDBH = Medical Behavior; RSCH = Research; TRANS = Transitional Soldiers; OTH = Other

Limitations

There are a number of limitations associated with this study. First, using secondary analysis has some inherent fundamental limitations that must be taken into account. When one uses secondary data, such as what I obtained from the CDC and

WHO, one has to be prepared for a potential lack of contemporary relevancy if the data is dated and there is some belief that different trends have emerged since the data was originally collected. Second, there is the risk of incomplete and/or missing material or findings associated with data obtained for secondary analysis. With respect to this study, for example, the CDC uses a manual system to input information on an individual's reported death, which differs from the Army's reporting protocols. Thus, while the Army might show one number for suicides within a certain period, the CDC may show a different number for that same period. As the study indicates, the Army has shown an increase in suicides over the past four years; yet the actual suicide number for the CDC over the same four-year period is not known and/or at least cannot be assumed to correlate well with the Army's corresponding figure.

A third limitation is linked to the fact that researchers may encounter problems with reliability and validity, as well as inadequate documentation and/or articles that may be suspect when it comes to probability. In order for a researcher to stay ahead of this type of issue, he/she must be aware of where data comes from, as well as the specific research intent for which associated data was captured—if that applies. This brings one to data quality. In some cases, data captured from Army sources represent information of which the researcher was previously unaware; thus, there is the possibility of errors in data collection and/or sampling errors that may be identified within the study. As an example, such issues were discovered within articles where certain conclusions were drawn with respect to suicide—but which were disputed in other articles. Therefore, this study required significant content analysis when analyzing a number of sources on a subject that at the time was receiving a great deal of attention from different agencies.

The fourth and final limitation is that when one uses secondary data, it is restricted to what already exists. This may limit the researcher in evaluating more contemporary staff or client opinions, needs, or satisfaction levels.

Despite these limitations, this study has merit in exploring the complex issue of suicide in the Army, as well as bureaucracy involved as the Army continues to address this growing problem.

CHAPTER 4.

MAKING SENSE OF SUICIDE AND THE BUREAUCRATIC PROCESS

This chapter traces the bureaucratic processes by which the US Army defines a soldier's death as a suicide and attempts to assign an explanation of the suicide in terms of precipitating factors. The key issue for this dissertation in this history is that the Army is not struggling with the problem of labeling the death "suicide" but with the problem of assigning a reason for the suicide. In Chapter 6 "Discussion of Findings," I explore in terms of labeling theory the various factors that affect the reasons assigned. Here, in this chapter, I give a description of what I have learned through document analysis of the process by which reasons for the suicide are assigned. I follow the methodology I discussed in Chapter 3 on document analysis.

As a "total institution," the US Army has a process in place to address the death of one of its own, whether it results from a homicide, suicide and/or accidental death. Similar to any other task or responsibility, the Army has instituted specific policies and associated personnel to investigate any death that occurs among its members. The various Army agencies that have oversight in such cases attempt to coordinate and ensure that all circumstantial facts associated with a soldier's death are not only reported, but that the information is also confirmed and validated through a number of auxiliary sources/events, such as via established Department of Defense channels.

Department of Defense Suicide Event Report (DoDSER)

The Department of Defense (DoD), which is headed by the President of the United States, is the largest government agency in the U.S. In addition to housing the Army, Navy, Marine Corps, and Air Force—consisting of about 1.4 million men and women on active service duty[27]—a handful of other major agencies (e.g., the Defense Intelligence Agency and the National Security Agency) are also under the purview of the DoD. These various DoD arms make it the single largest agency of the U.S. federal government with the largest number of employees. Because of its significant oversight responsibilities, which include asking our nation's men and women to engage in combat and protecting the security of our country, the DoD has a role when it comes to the suicide of any military employee.

One way that the DoD documents military suicides is through the Department of Defense Suicide Event Report (DoDSER),[28] which is a software-based program developed collaboratively in 2008 by the Suicide Prevention Program Managers of all service branches (Army, Air Force, Marines, and Navy). This program can only be accessed through a secure website and is available only to authorized individuals. In order to investigate suicide fatalities and compile risk factor data, the DoDSER collects both objective and subjective information in various categories: comprehensive event data (method, location, fatality), dispositional/personal (e.g., demographic information),

[27] About.COM; U.S. Government Info; is a government site that updates information concerning the military

[28] Surveillance tool used to gather risk and protective factor information on suicides, suicide attempts, self-harm events and suicidal ideations

historical/developmental, contextual/situational, and clinical/symptomatic (e.g., diagnoses). It is important to note that data from the DoDSER is sent directly from a behavioral health provider to the DoD without first coordinating with the Army's (or other service branch's) medical and/or law enforcement personnel, which helps to ensure quality assurance in submitting the report.

As documented and discussed in Chapter 1, suicides in the military are on the rise—particularly among regular enlisted personnel, which, of course, make up the bulk of our nation's military forces. As shown in Figure 5, when the DoDSER was first developed in 2008, suicide deaths among active duty personnel had been increasing over a seven-year period, with the most precipitous rise beginning in 2005 (two years into the War in Iraq).

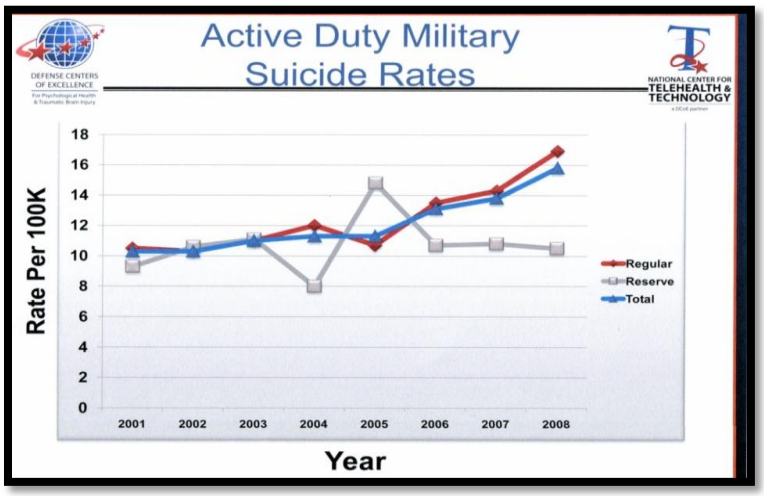

Figure 5. Active Duty Military Suicides Increase from 2001 – 2008
(adapted from *https://**dod**ser.t2.health.mil/*
www.dcoe.health.mil/DCoEV2/Content/navigation/documents/gahm.pdf)

Information Coordination and Related Agencies

The Army coordinates with the following four individuals/agencies when it comes to the notification and confirmation of a soldier's suicide: the United States Army Criminal Investigative Division (CID), the Armed Forces Medical Examiner (AFME), the soldier's Commander,[29] and a Commander at the Medical Treatment Facility (MTF) within the soldier's command. While it might seem that "post-event" information is thoroughly disseminated, according to the Army 2010 Report the organization's current policies and processes for investigating and reporting criminal behavior do not provide sufficient information for commanders to properly manage their at-risk population. Additionally, the report cited the lack of a central repository for the three types of investigations: a *commander's inquiry, the military policy report, and the CID investigation report*—all of which should be able to be accessed so that data can be analyzed and reviewed by commanders and law enforcement personnel. The report suggests that one of the effects of this disjointed system is evident in the processes used to notify the families of fallen soldiers. In other words, the lack of coordination between agencies has resulted in conflicting and contradictory information, causing confusion where there should be clarity when it comes to reporting a soldier's death.

United States Army Criminal Investigative Division

The U.S. Army Criminal Investigation Division (CID) is a federal agency that provides investigative services to all levels of the Army. In fact, it is the sole criminal

[29] Person in charge of soldiers; units; division; organizations; missions. The term "commander" is officially applied to the commanding officer of army units; hence, there are company commanders, battalion commanders, brigade commanders, and so forth.

investigative agency for non-combat deaths (Army 2010). The roots of this organization literally date back centuries. Although it was not initially called CID, the original training focus of this law enforcement agency was on instilling military discipline to those in the Continental Army in the late 1770s.[30] This focus remained until World War I when in 1918 the Provost Marshal General of the American Expeditionary Forces organized a criminal division as part of the Military Police within the Army, which became known as the Criminal Investigation Division (CID). Since that time the CID has been comprised of personnel from military police units within the Army. The first CID Commander took charge of the division in 1971 with a mission to investigate and prevent crimes. Currently, CID collects, examines, processes, and disseminates criminal intelligence; provides support to forensic laboratories that support DoD investigative agencies; and provides criminal investigative support to the US Army worldwide.

Regardless of the cause, when an Army soldier dies the first agency on board to investigate is CID. A death that results from suicide is termed a "non-combat death," meaning that the soldier's death did not occur during combat. Typically, CID initiates their investigative process by appointing a Special Agent in Charge to serve as the lead investigator. That individual not only *collects* any *physical evidence* involved in the death, but also speaks to relatives, friends and others that knew the solider. However, when a soldier's death occurs *outside* of an Army installation, CID will assist external agencies (local police, for example) in investigating the soldier's death. Because CID does not have the same investigative authority when it comes to soldiers who die "off

[30] Formed by original colonies that eventually became the United States of America.

post," its role in that process is limited. Important to mention is the fact that CID does not determine how a person died; rather, a forensic pathologist will make that determination based on the known facts and circumstances of a case. This information is then compiled with the findings of the autopsy and lab tests, allowing the pathologist to make an informed determination.[31]

The following sequence of events is representative of how CID investigates the "on post" death of a soldier, regardless of whether the death is combat-related or occurs from suicide:[32]

1. The agency receives notification of the death.
2. CID personnel go to the location where the death occurred (if circumstances permit).
3. CID documents and evaluates the scene of the death.
4. CID documents and evaluates the status of the body.
5. CID collects inventory and safeguards property/evidence.
6. CID documents any additional activity at the scene.
7. CID personnel receive and evaluate autopsy results.
8. CID personnel conduct a forensic analysis.
9. Any additional activity deemed necessary is conducted to complete the investigation.

[31] Findings identified from US. Army Criminal Investigation Command Website that answers questions concerning CID and the process of CID. A limited website. www.cid.army.mil/faqs.

[32] Criminal Investigation Slide Deck; addressing CIDs philosophy on death investigation and suicidal statistics; Dec 2009.

As indicated earlier, three other important individuals/organizations are brought in to investigate the death of active duty personnel: the Armed Forces Medical Examiner (AFME), the individual's commander, and the Military Treatment Facility (MTF) Commander. Their roles are responsibilities are detailed in the following sections.

The Armed Forces Medical Examiner (AFME)

The Armed Forces Medical Examiner (AFME), which operates under the Armed Forces Institute of Pathology and is based out of Walter Reed Army Medical Center in Washington, D.C., is responsible for determining the cause and manner of death of members of the Armed Forces on active duty. AFME is also responsible for identifying bodies of military personnel. The Army replies on AFME to confirm the manner and cause of death, whether it be suicide, homicide, accident or natural causes. In cases where a death results from causes that could either be accidental or self-inflicted (e.g., a gunshot wound, drug overdose, asphyxiation, etc.), AFME investigators have to be very careful when classifying a death as one or the other. AFME conducts a thorough forensic investigation of a soldier's suicide and/or suspected suicide. The agency also works closely with CID to ensure that a soldier's death is classified accurately.

According to the Army's 2010 Report, the medical examiner's responsibility to determine manner of death is not an easy one, particularly if suicide is a possibility. "Accidents and suicides … 'are difficult distinctions to make sometimes, particularly if someone doesn't leave a note or indicate in any way they were contemplating suicide'" (2010 Report: 189). Since AFME does not have the authority to designate "pending" and/or "undetermined classification" on a soldier's death certificate, the death

investigation must be completed in such a way so that the manner/cause of death can be identified, regardless of the complexity or any ambiguity involved. AFME/CID collaboration is often adversely affected by the timing between issuance of the death certificate and resolution of all investigative leads. Conflicting conclusions may communicate inconsistent information to the victim's family regarding the manner of death (Army 2010 Report), which is a dilemma that all parties strive to avoid. Therefore, AFME and CID work closely together before a *final* decision regarding a soldier's death is announced. This collaboration includes obtaining information from the soldier's family, particularly if suicide is suspected. As documented in the Army 2010 Report, the total process of investigating and collaboration can take months. Once an initial determination has been made, the next step is to notify the soldier's commander of the official cause of death.

The Soldier's Commander

When a death occurs, the deceased individual's commander must be notified within 12 hours of the event. Once notified, the commander is required to initiate a report on the soldier's death, which contains important information (especially in the case of suicide) such as a soldier's personal information, medical/behavioral issues, family and or work issues, as well as any suspected drug/alcohol dependency. When suicide is suspected, commanders are also required to submit a "34 Line Report"[33] to the Army Suicide Prevention Program (ASPP) within 30 days of a soldier's suicide and/or

[33] Commander's 34 Line suicide reporting format, Appendix F; AR 600-24; identifies fields used to complete the report.

equivocal death being investigated as a suicide (Army Report 2010). The Army describes the 34-line report as a specific report; that it is used by CID in order to brief Army Leadership; that it is a report that is continuously modified based on requirements for additional data; and finally that it is prepared using information from the AR 15-6 inquiry process, which will be detailed in the next section of this chapter.

The 15-6 Procedure

The specific protocol a Commander uses to initiate an investigation into a soldier's death stems from procedures for informal investigations established in Army Regulation (AR) 15-6. The regulation is essential for investigating a suspected suicide death of a soldier. The purpose of an AR 15-6 investigation into a suspected suicide is to identify the circumstances, methods, and contributing factors surrounding the event. Among other things, the investigation examines the soldier's behavior before the event, as well as actions taken by the soldier's chain of command. The 15-6 investigation is a fact data-gathering tool for the commander and is directed by an officer or a board of officers in order to ascertain facts and make findings and/or recommendations. In order to initiate the process, the commander assigns an appointed investigative officer (IO) to the soldier's case. That IO is then responsible for ensuring that the completed investigation provides clear, relevant, and practical recommendation(s) in order to prevent future suicides. Every investigation has the same basic objectives:

- To collect, assemble, and preserve evidence.
- To find facts known to be true and those that may be presumed from all the evidence.

- To make determinations and recommendations for administrative disposition.
- To gather the best available evidence with the least possible delay.[34]

Before proceeding with the investigation, the IO is guided by the Office of the Staff Judge Advocate (legal process) and the Line of Duty (LOD) report, which gives some sense of the status of the solider at the time of his or her death. The IO contacts the U.S. Army Criminal Investigation Command (CID) office to obtain relevant factual information, including preliminary reports. The investigation also includes coordination with relevant behavioral or other health providers, as well as with the Office of the Armed Forces Medical Examiner. Coordinating with AFME takes place in order to obtain information related to any prescription drugs taken by the deceased, the autopsy and toxicology reports, etc. Any pertinent medical information is used as exhibits in the report before completion of the findings and recommendations).

Throughout the investigation the Commander is guided by an Army Directive known as the *Guidance for Investigating Officers Conducting an AR 15-6 Investigation of a Suspected soldier Suicide. The* following four categories list the questions the Investigating Officer participating in a 15-6 investigation will ask of those involved in the soldier's life—including his/her army unit, the deceased member's family, and any other relevant individual who might be able to shed light on the rationale behind a soldier's suicide (Table 4).

[34] https://rdl.train.army.mil/soldierPortal/atia/adlsc/view/public/9420-1/fm/27-1/Ch8.htm

Table 4. AR 15-6: Investigation Questions by Category

1. COMMUNICATION OF SUICIDAL INTENT
• Were there any gaps in the policies, processes and programs necessary to mitigate high risk behaviors? • Did the soldier communicate a threat of suicide and, if so, to whom? • Was the communication(s) written, spoken, or nonverbal? Give examples. Explain the circumstances surrounding the suicide attempt(s). • Was the chain of command aware of the suicide threats and, if so, how did it react to the threats (referral to chaplain, combat stress team, mental health provider, other)? • What was the diagnosis or opinion of these professionals if the soldier was referred? • Had the soldier previously attempted to commit suicide? If so, provide a history of the attempt(s) and response(s), and indicate what led to those previous attempts? • Who was the last person to speak with or see the soldier before the suicide? What was discussed? What did that person observe or hear, what did that person think or perceive about the soldier, and what actions did that person take? • Had a behavioral health provider, primary care provider, or chaplain seen the soldier within the last 30 days? (Note: the chaplain may confirm whether command referred the soldier for counseling, but cannot reveal the details of pastoral conversations. The policy on absolute confidentiality requires the chaplain to uphold confidential communication, even after the death of the counselee.)
2. PERSONALITY AND LIFESTYLE
• What was the soldier's basic personality (relaxed, intense, jovial, gregarious, withdrawn, outgoing, morose, bitter, suspicious, angry, hostile, combative, other)? • Was the soldier's personality and demeanor before the suicide different from his or her normal behavior • Explain any recent change(s) in mood or symptoms of mental illness. • Explain any recent change(s) in behavior, such as eating, sleeping, social relationships, drinking, or drugs. • Describe the soldier's friendship group. Were there many/few/casual, or intense friendships • Explain any recent withdrawal from a friend(s) or acting out, such as gambling, overspending or fighting. • Explain how the soldier spent his or her free time.

- Did the soldier experience a recent loss (death, breakup of a relationship)? Explain.
- Did the soldier have any significant financial issue(s) or problem(s)? If so, describe the nature of the problem(s).
- Did the soldier have any significant health problem(s)? If so, describe the nature and treatment of those problem(s).
- Is there any indication that the soldier was experiencing difficulties in a relationship with a spouse, partner, parents, or children? If so, describe the nature of the conflict(s).
- Did the soldier have any communication(s) on the Internet (that is, with social networking sites)?
- Was the soldier currently taking any prescription drug(s)?
- What was the soldier's religion and was the soldier active in any religious programs?

3. MILITARY HISTORY

- Determine time in service, time in grade, months assigned to present unit, date of last permanent change of station (PCS), date of pending PCS, awards.
- Explain any Uniform Code of Military Justice actions (article 15s, courts martial) or other adverse administrative action(s).
- Explain any pending unfavorable personnel action(s) (bars to reenlistment, weight control, Army Physical Fitness Test).
- Explain any counseling statement(s). (By whom? when? why?)
- What type of suicide prevention or resiliency training did the soldier participate in and in what timeframe?
- What was the soldier's previous deployment history? How many deployments had the soldier been on (number, length of deployment, nature of work while deployed)?
- When did the soldier complete the suicide stand-down/training[35]?
- How many unaccompanied tours had the soldier been on?

4. OTHER

- What did the immediate group of officers, noncommissioned officers, government civilians, contractors, and peers think of the soldier?
- Had the soldier been singled out or harassed? Explain by whom and why.

[35] Stand-down training was a requirement for all soldiers as the suicide numbers began to escalate. Soldiers were required to attend sessions that addressed suicide prevention.

At the end of the AR 15-6 investigation, the responsible CID officer will be asked to identify and resolve any discrepancies in fact findings that may have been discovered during the 15-6 investigation, as well as to ensure that no key matters of evidence are overlooked that might have an effect on the findings and recommendations pertaining to the soldier's death. If any medical information is found to be significant in the soldier's death, it will also be reviewed for any findings and/or recommendations by behavioral health providers and/or medical examiners.

Medical Treatment Facility (MTF) Commander

The soldier's MTF Commander is responsible for submitting a DoDSER to the Department of Defense within 60 days after a soldier's death has been ruled a suicide by AFME. It is at this point (i.e., when the DoDSER is submitted and the suicide ruling is final from the Army's perspective) that the Army can close its official investigation. Therefore, DoDSER must be accurate prior to the MTF Commander submitting the report to the DoD. It should be noted, however, that CID, AFME and the leadership in the soldier's unit continue to have a role in taking care of all that surrounds the soldier's death. Another military organization that also plays a significant role from the outset in addressing a soldier's death is the Casualty and Mortuary Affairs Operations Center (CMAOC).

Casualty and Mortuary Affairs Operations Center (CMAOC)

The CMAOC is the centralized agency for the casualty reporting system. Specifically, the *Casualty and Mortuary Affairs Branch* (CMAB) is responsible for coordinating death investigations and issuing appropriate documentation. For example,

the CMAOC's Casualty Notification Office will provide the soldier's next-of-kin with the death notification. This office also lends administrative support to the soldier's family, as well as becomes a liaison to any other agencies involved in notifying the next-of-kin.[36]

Once notified by the unit of a soldier' death, the CMAOC notifies the appropriate Casualty Assistance Center (CAC), which then appoints a Casualty Notification Officer (CNO). The CNO is responsible for issuing the initial death notification and coordinates to ensure that there is a Casualty Assistance Officer (CAO) available to work with the fallen soldier's family as the appointed Army liaison. The CAO will maintain personal contact with the next-of-kin for as long as needed. As such, the military service office will attempt to appoint a CNO that is in geographic proximity to the primary and secondary next-of-kin. During the actual notification visit to the family, the CNO may be accompanied by other military representatives—i.e., that individual's commanding officer, one or more unit member(s), and/or a chaplain. Depending on circumstances (e.g., family members cannot be found, live abroad, etc.), this protocol could change. Thus, the CNO must address every death on a case-by-case basis.

As the primary benefits administrator, the CAO also works with the deceased soldier's family to ensure that all administrative paperwork and associated tasks are properly carried out (financial, memorial services, Department of the Army Forms, etc.). Additionally, CMAOC makes available to the family any investigative documents that are germane to the case and are not classified for some reason. In summary, the main

[36] Roles and Responsibilities of the CMAOC, CID, AFME and leadership explained in 2010 Report.

responsibilities of the CAO are to offer support for the family, provide timely notification of the death, make available accurate information, protect the family's privacy, and in general be responsive to the family's needs.

The Next of Kin Notification

When it comes to notifying a deceased soldier's next-of-kin, the Army and DoD have specific guidelines/timelines associated with this process. However, despite established policies and procedures, it is not always done quickly; nor is it accomplished without incidence. There can be unforeseen factors that slow down (or regrettably speed up) the process—and this can present challenges that Army leadership may not be prepared to address. For instance, today's high tech communication environment means that information can escape in detrimental ways. A family may learn of their relative's death—or the circumstances involved therein—through "the grapevine," rather than through customary ways that are intended to mitigate the loss of the individual. There may also be a notification delay due to a soldier's emergency data information not being updated with the most current next-of-kin data, and/or the inability to reach a family member. Therefore, early coordination with the previously mentioned agencies/individuals is critical in order to have accurate and timely information when notifying the soldier's family. Understandably, most families want to know exactly when, where, why and how their son/daughter, spouse, mother/father died. Having this information at hand is crucial during the notification process. And as noted above, specific organizations have proscribed roles when it comes to notifying and assisting

next-of-kin at the time of a soldier's death. The following organizations have a role in this process: CID, AFME, and Unit Commanders

CID: the CID Special Agent in Charge is also the Casualty Liaison Officer (CID CLO). Once the next-of-kin have been informed of the death by the Casualty Notification Officer, the CID CLO representative is required to brief appropriate family members about the status and results of the investigation within five days of the CNO's contact with the family. After the initial notification, the CID CLO is responsible for contacting the next-of-kin once every 30 days to keep them updated on the status of the investigation.

AFME: AFME's responsibilities include releasing the autopsy results as well as issuing the death certificate to the next-of-kin.

Unit Commander: Upon the CNO's completion of next-of-kin notification, the unit commander has 24 hours to send a sympathy letter explaining the details surrounding the soldier's death. In a deployed environment or other overseas locations, the commander has 72 hours to issue the letter. At 30-day intervals, the commander will report to CMAOC any new factual information gained throughout the investigation, even if the investigation is on-going. These reports will continue until the investigation is complete. Subsequently, the commander will send follow-up letters to the family every four to six weeks—or sooner—if new information is available.

Summarizing Investigating, Reporting and Notification

The Army accepts responsibility for not only the health and welfare of its soldiers, but is also committed to the health and welfare of a warrior's family. When a soldier dies,

there is no mission more important than the next-of-kin notification process to ensure timely, accurate and consistent information. However, multiple participants can make this process complex since the soldier's immediate commander, the CID, the CMAOC and the AFME all have a role in communicating with the family. Therefore, these organizations and individuals must intentionally coordinate their activities during all formal and informal communication as a synchronized and highly sensitive process.

Together, AFME and CID provide a comprehensive picture as to the cause, nature and circumstances of death. Despite the best of intentions, however, their necessary collaboration toward issuing the death certificate can be adversely affected by investigative snafus. Currently, there is no formal mechanism (e.g., "manner of death review board") to reconcile differing conclusions as to the actual cause of a soldier's death—which is more common among soldiers who take their own lives. For example, it is possible for a gun to misfire and accidentally kill the man in charge of the firearm. Ultimately, however, was it accidental or was it suicide? As a result of such ambiguities, both organizations may publish conflicting findings and communicate conflicting information to the victim's family, which only compounds the tragedy of their loss.

Therefore—especially in the case of a suicide—it is essential to develop policies and processes that will synchronize investigative conclusions regarding the victim's intent in determining the manner of death. To help achieve this goal, AFME must delay (to the extent possible) its determination of the manner of death pending final investigative conclusions.

Commanders, law enforcement personnel, and medical providers have multiple means of investigating and reporting high-risk, non-fatal behaviors and high-risk deaths.

Although investigative reports (AR 15-6, LOD and criminal/death) provide the facts and circumstances surrounding the high-risk event, there are numerous gaps in interagency investigations and investigative reporting. For example, investigations are uncoordinated and results are not easily accessible to decision makers. As a result, data concerning high-risk behaviors are not readily accessible to track incidents, determine trends and conduct predictive analyses (Army, 2010 Report). This lack of accessibility and synchronicity is also evident in death investigations that occur outside the military's jurisdiction, which adds another layer of complexity in the investigative process, manner of death determination, and reporting procedures (Army 2010. Conversely, a process that is timely and synchronized can ultimately help to mitigate a family's unbearable loss. As documented in the Army 2010 Report, however, existing investigative and reporting policies and processes are disjointed and incomplete. They lack a clear delineation of roles and responsibilities and currently fail to promulgate standard procedures and definitions when it comes to a soldier's death.

CHAPTER 5.

RACE AND GENDER:

SUICIDE STATISTICS AND THE US ARMY

Suicide Statistics

Although this study was not intended to examine the incidence and motivation for suicide among the broader, non-military population, some comparative statistics are justified. According to the National Institute of Mental Health (NIMH, 2011), suicide was the 10th leading cause of death in the U.S. in 2007, accounting for well over 34,000 deaths. The NIMH also concluded that 11 attempted suicides occur per each actual suicide death, which translates to a very serious problem. Moreover, despite the fact that all Americans, regardless of racial/gender group, are impacted by suicidal behavior, some risk factors vary according to age, gender, and ethnic group.

The Centers for Disease Control and Prevention (CDC) is also a repository for suicide data. This agency is responsible for collecting, analyzing and publishing fatality statistics in the United States using the National Vital Statistics System. Because it is a manual system, it can take anywhere from 18-24 months to compile, verify and prepare data for public release. According to CDC 2007 Minority Report, of the more than 34,000 suicides in 2007 (equivalent to 94 suicides per day; one suicide every 15 minutes, and with a incidence rate of 11.26 per 100,000), 83.5% were among whites; 7.1% among

Hispanics; 5.5% among Blacks; 2.5% among Asian/Pacific Islanders (A/PIs); and 1.1% among American Indians/Alaskan Natives (AI/ANs). It should be stressed, however, that AI/ANs are actually at the highest risk for suicide with an incidence rate of 14.3 per 100,000 individuals, followed by non-Hispanic Whites at 13.5 (NIMH, 1011). The lowest rates in 2007 were among Hispanics (6.0 per 100,000; non-Hispanic Blacks (5.1 per 100,000) and A/PIs (6.2 per 100,000).

In terms of gender distribution, the overall suicide rate for males (18.4 per 100,000) was approximately 4 times higher than that of females (4.8/100K). All racial/ethnic groups show higher rates for males than for females; however, the ratio differs among the groups (Table 5). The South and West regions led in the number of suicide deaths (Table 6). Table 7 represents a complication of the suicide data by gender and ethnicity.

Table 5. Male To Female Suicide Ratio by Ethnic Group

Racial/Ethnic Group	Male to Female Ratio
Whites	3.8 to 1
Hispanics	5.0 to 1
Blacks	5.0 to 1
Asian/Pacific Islanders	2.4 to 1
American Indians/Alaskan Natives	3.7 to 1

Table 6. Geographic Distribution for Suicide in the U.S.

Region	Number of Suicides	Percentage (%)	Crude Suicide Rate/100K
West	8,940	25.8%	12.8
South	13,389	38.7%	12.1
Midwest	7,515	21.7%	11.3
Northeast	4,754	13.7%	8.7

Table 7. Number and Rate of Suicides by Race/Ethnicity and Sex

Race/Ethnicity*	Male		Female		Total	
Characteristics	No. of Deaths	Rate	No. of Deaths	Rate	No. of Deaths	Rate
White, non-Hispanic	22,660	22.9	6.237	6.1	28,897	14,4
Black, non-Hispanic	1,571	8.7	345	1.7	1,916	5.1
American Indian/Alaska Native	290	23.2	80	6.2	370	14.6
Asian/Pacific Islander	612	8.9	266	3.7	878	6.2
Hispanic	2,078	8.9	387	1.8	2,465	5.4
Unknown	58	-	14	-	72	-
TOTAL	27,269	18.4	7,329	4.8	34,598	11.5

National Vital Statistics System, United States, 2007

* Rates for persons with unknown race/ethnicity were not included.

The CDC 2007 findings also reported the following comparisons about racial and gender disparities with respect to suicide:

- ✓ Males take their own lives at nearly four times the rate of females and represent 78.8% of all U.S. suicides.
- ✓ During their lifetime, women attempt suicide about two to three times as often as men.
- ✓ Suicide is the seventh leading cause of death for males and the fifteenth leading cause for females.
- ✓ Suicide rates for females are highest among those aged 45-54 (rate of 8.8 per 100,000 population).
- ✓ Suicide rates for males are highest among those aged 75 and older (rate of 36.1 per 100,000).
- ✓ Among American Indians/Alaska Natives 15 to 34 years of age, suicide is the second leading cause of death.
- ✓ Suicide rates among American Indian/Alaskan Native adolescents and young adults aged 15 to 34 (20.0 per 100,000) are 1.8 times higher than the national average for that age group (11.4 per 100,000).
- ✓ Suicide ranked as the eighth leading cause of death for American Indians/Alaska Natives of all ages.
- ✓ Hispanic and Black, non-Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (11.1% and 10.4%, respectively) than their White, non-Hispanic counterparts (6.5%).
- ✓ Suicide is the second leading cause of death among 25-34 year olds

- ✓ Suicide is the third leading cause of death among 15-24 year olds.
- ✓ Among 15-24 year olds, suicide accounts for 12.2% of all deaths annually.
- ✓ There is one suicide for every 25 attempted suicides.

US Army Demographic Information

In the 2009 "Population Representation in the Military Services Fiscal Year (FY) Report," the Army listed an active-duty end strength of 549,015 individuals, which is less than the official authorized end strength of 569,000. That 2009 figure represents growth of just under 10,000 soldiers from the service's FY 2008 end strength of 539,675. The most current figures (FY 2010) show that the Army's end-strength population reflected a total of 561,979 active duty personnel.[37]

The Human Resources arm of the US Army provides important demographic information, which has wide-ranging analytical and policy implications to support senior-level decisions relative to the readiness of the force, as well as human resources policies and programs that impact the Total Army community (i.e., active-duty soldiers, Reserves & National Guard personnel, retirees, family members, veterans, and Army civilians). These Army-wide analytical and policy recommendations are also important as they relate to suicide.

The Army is the largest military organization in the United States and by far the most diverse in terms of the number of members (soldiers) serving in a military organization. A 2008 report entitled, *Changing Profile of the Army*, includes the following statement with respect to EO/AA and diversity efforts:

[37] http://prhome.defense.gov/MPP/ACCESSION%20POLICY/PopRep2009/summary/PopRep09Summ.pdf//

> Since the Armed Forces were officially desegregated by the signing of Executive Order Number 9981 in 1948, the Army has been at the forefront of racial/ethnic diversity and equal opportunity for its Soldiers. Over the past several years, the Army has been proactive and aggressive in its efforts to not only recruit and train a diverse cadre of Soldiers, but to implement programs that are designed to facilitate the education and promotion of its qualified and racially/ethnically diverse workforce. (p. 5)

In terms of the Army's diversity, research shows that African Americans are overrepresented as a minority, while females, Hispanics, Asians, etc., are all underrepresented. Further, although there may be gender issues when comparing minority groups, there is an important similarity among the various service branches—namely, the military's efforts to improve the racial and/or gender integration of soldiers who are needed in order to maintain an effective combat environment. Even throughout the 1950s and '60s, the military was far ahead of civilian institutions with respect to racial integration. According to Segal (1989), this advantage is likely associated with factors such as military discipline, imposed diversity policies in military institutions and/or acknowledging the contributions of "lower" enlisted individuals, regardless of the soldier's race. However, Segal also suggested that these influence(s) were not without problems for "those" military service-members. Specifically, he asserted that although minority members were reasonably well integrated within the military, they could still face hostility and discrimination issues when they were away from their assigned military location.

If there is indeed an advantage when it comes to the racial/ethnic/gender integration of Army personnel compared to civilian organizations, has it come at a price in terms of achieving the military mission? In other words, has the goal of diversifying its

rosters to achieve stated racial and gender enlistment goals caused the Army to lower standards over the past several years? And if it has, what role (if any), has this played when it comes to the increase number of suicides?

Women

The first women to "join the Army" did so during the 1700s when they served in a largely informal way as nurses, cooks, laundresses, and even as spies by carrying messages and transporting contraband during the Revolutionary War. Women continued to serve during the Civil War—primarily in nursing roles. In fact, of the approximately 6,000 women who performed nursing duties for the federal forces, it is estimated that about 180 Black nurses served in convalescent and U.S. government hospitals during the war. "Official" status was granted via Public Law 36, which was passed on Congress in April, 1947. This legislation established the Regular Army Nurse Corps branch in the Army, and allowed them in the Army National Guard and Air Guard. Since that time, women have been wearing uniforms and in one way or another have been a part of the many conflicts in which the United States has engaged. It has been said that today's "War on Terrorism" underscores enlisted women's dedication and willingness to share great sacrifices.[38] Despite this fact and the increased presence of women in the military over the past several decades, there continues to be vary degrees of opposition to their presence—especially in higher leadership positions and more particularly during combat (Mitchell, 1989; Tuten, 1982; O'Beirne, 2006; Webb, 1979; Revels, 2004; Galland, 2002; Mohler, 2004; Downing, 2003; Check, 2002). Nonetheless, to date women serve in 91

[38] http://www.army.mil/women/today.html

percent of all Army occupations and make up approximately 14 percent of the Active Army, which is a significant number.

It is clear, therefore, that the contributions of women in today's Army (as well as in the past) have not been without sacrifice. As an example, of the 58,272 names on the Vietnam Veterans' Memorial in Washington, DC, 8 of them represent female casualties—7 of them Army personnel. Similar to their male counterparts, the sacrifice of women has also included death by suicide.

As reported by Rojas-Burke in December, 2010, females in the Army have experienced an increase when it comes to suicidal death. "Young women who've served in the military face a suicide risk triple that of non-veterans" (para 1). It should be stressed that while approximately 7500 women served during the Vietnam War, the number of women who are currently serving or have served in Iraq and Afghanistan is over 30 times that amount (i.e., currently over 250,000). These tandem conflicts mean that the military is attracting greater numbers of women and exposing them to more combat situations that have the potential to put them at risk for more brain and other combat type injuries. Equally important is the associated stress—both on the front lines and elsewhere.

> Soldiers in Iraq and Afghanistan live under constant threat of attack and endure months away from spouses and children. Alcohol and drug abuse, used by some to cope with stress, increase suicide risk. However, not all military women in the study served overseas. Many women in the military face the added threat of sexual violence. In a study of 21,800 women veterans who served in Iraq, 15 percent experienced sexual assault or harassment while in the service. (Rojas-Burke, 2010, para 7-8)

Thus, women in the military are at risk for the same potentially catastrophic injuries and post-traumatic stress disorders that are translating to higher suicides rates.

Hispanics

As reported by the U.S. Census Bureau, the U.S. Hispanic population grew four times faster than the aggregate population between 2000 and 2010. This group now makes up about 16% of the total population (i.e., over 308 million individuals) (Aguilera, 2011). Despite the national growth of Hispanics, they still represent a relatively low number of soldiers in the US Army. While the research indicates that Army leadership and the DoD would like the enlisted ranks to reflect the racial/ethnic and gender makeup of America, findings indicate that the Army has not been very successful in meeting such numbers, despite the fact that the Hispanic community views the military in a positive way. In fact, findings generally indicate that Hispanics are entering the military for the same reasons reported by other minorities—principally to avoid the trap of gang activity, and generally wanting to be successful in their lives.

In a 2009 Department of Defense report, "Population Representation in the Military Services," Hispanics are included not as a racial category, but as a separate ethnic category and within this report Hispanics accounted for 15.8 percent of FY 2009 accessions (gains) and 11.7 percent of the FY 2009 current Army force. Moreover, according to Army statistics, even though Hispanics represent about 18 percent of the entire "recruitable" civilian population aged 18-24, they currently comprise about 13 percent of Army recruits. Additionally, in terms of suicide and the Army current research shows Hispanics account for 10 percent of suicide (Los Angeles Times, Sept 2005).

> Over the past several years, Hispanics have demonstrated a high propensity to serve in the Army. Their percentages have increased steadily and significantly since FY95, just as their numbers in the U.S. population have grown substantially. Despite their growing numbers in the general population and in the Army's enlisted force, the percentage of Hispanics in the Army continues to fall below representation in the U.S. population.
> http://www.armyg1.army.mil/hr/docs/demographics/Changing

Therefore, as a population that is increasing nationwide Hispanics could potentially represent an important segment of the Army's enlisted ranks.

Asians

Among the major ethic groups, Asian-Americans represent the lowest rate of Army membership. Specifically, Asian-Americans make up about four percent of the US population, but only about one percent of recruits. This low rate, however, seems to be changing. Asian-Americans in California as well as in other communities with a higher representation of this demographic (e.g., Seattle and New York City) have been enlisting in the Army in increasing numbers. During 2009, Los Angeles County-based Army recruiters identified 22 percent of Army recruits as Asian-Americans which showed that the proportion of newly-enlisted Asian-American soldiers double in one year (Shavelson, 2010, para 3).

In terms of the incidence of suicide among Asian-Americans, a 2011 study from the National Institute of Mental Health (NIMH)[39] indicated that even though self-identified Asian-Americans make up 3.5 percent of the Army, they accounted for 9.5 percent of the suicides. NIMH also showed that this disproportion was evident before,

[39] NIMH was hired by the Army and provided suicide statistics/findings based on a report that covered over 900,000 Soldiers which included Soldiers who served time in Iraq and Afghanistan 2004-2008. This report identified risk factors as well as numbers. http://pn.psychiatryonline.org/content/46/9/1.2.full.

during, and after deployment. In summary, although the NIMH report indicated that the absolute number of Asian-American suicides was still relatively small—equaling 37 individuals over a four-year period—the report confirmed that Asian ethnicity appears to be a risk factor when it comes to suicide.

African Americans

The US Army has more African Americans[40] serving in its ranks than any other service branch. Unlike most other employment opportunities, the history of Blacks in the military has always been associated with a certain degree of freedom and economic stability (Mosko & Butler, 1996). Although Black soldiers have participated in every war in which the United States has engaged, it wasn't until the Korean War that their status became "equal"[41] to their White peers. In this context, the term "equal" refers to the removal of segregation, a quota system, and Black soldiers' exclusion from unequal combat specialties and selective officer commissions. According to Mosko and Butler, despite the inevitable institutional and personal challenges, soldiers see that the grass is not necessarily greener on the other side—that the Army is seen as a better place than what is or is not offered outside of the Army. Actually, this viewpoint is held by many young people in the Army, regardless of their ethnicity, economic status, or gender. The military is generally seen as a viable option for securing a better future.

Although Blacks are still overrepresented in the "total" Army (at 18.1 percent) compared to their overall national representation (12.6 percent according to the recent

[40] African American and the term "Black" will be used interchangeably throughout this dissertation.

[41] Equality dependent on the Army's definition; while the Author does not see the Korean war as a time that the US Army became an equal institution when it came to African Americans.

U.S. Census; see http://quickfacts.census.gov/qfd/states/00000.html), their numbers have been declining. As shown in Figure 6, in FY85 nearly one-quarter of the Army‘s soldiers were Black; sixteen years later the representation of Blacks in all components of the Army declined to 18.1 percent.

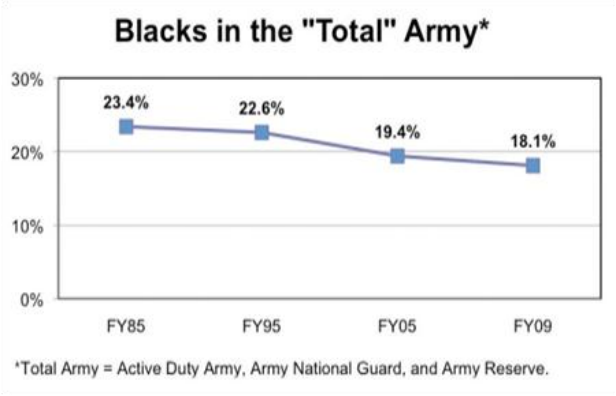

Figure 6. Blacks in the “Total” Army

This decline occurred at the same time that the representation of Hispanics in the Army was increasing, which is indicative of the changes that have occurred in the racial/ethnic composition in the U.S. population.[42] It should be noted, however, that in spite of the decline of Black soldiers, they continue to be represented at higher rates in the Army compared to other service branches. Additionally, in terms of suicide and the Army current research available shows African Americans account for 9 percent of suicide (Los Angeles Times, Sept 2005)[43].

[42] Army military doc: *Source: DMDC 3035 EO Report*)

[43] http://www.armyg1.army.mil/hr/docs/demographics/MRA_booklet_10-ARMY.pdf

Army Suicide Response

An essential fact that has driven this study is that suicide has been on the rise among Army personnel since the mid-2000s—and over the past few years has continued to increase. As discussed in Chapter 1, this rise in suicides led to the establishment of the Army's Suicide Prevention Task Force headed by the Vice Chief Secretary of the Army (VCSA)—a move that represented the Army's determination to confront this issue from the top and reduce the number of suicides. Despite this critical goal and the many associated efforts to educate personnel on leadership roles, war, deployments, stress, stigma, substance abuse, medical / relationship / financial issues, transitions, training, and so on, as of August 2011 suicides in the U.S. Army continued to escalate. As recent as July 2011, the Army suffered a record high of 32 suicides—the most suicides in one month since March 2009.[44]

As shown in Table 8, the 2010 Army Report identified the average suicide victim in the Army as a 23-year old, Caucasian, junior-enlisted soldier. If we further examine the composition of the "typical" suicide victim within the Army, we find an Active Component, 23 year old, Caucasian, junior-enlisted male soldier. These facts are documented in detail. For example, 86.6% of the Army population is male, while 96.9% of the suicide deaths in 2009 were male. Although 62.7% of the Army population is Caucasian, 76.7% of the suicide deaths were Caucasian victims (2010 Report, p.18). Unfortunately, this report does not show a breakdown between racial groups. Since the

[44] March 2009 is when the Army task force began tracking suicide numbers as data collected/used by the task force. The Army report used CDC 2007 data for comparison; CDC uses a manual process in their collection.

average suicide victim is likely to be White, the Army did not include other racial/ethnic information in the report.

Table 8. Active Duty Suicide Demographic Data

Active Duty Suicide Demographics	Active Duty Army 2009 Demographics	Active Duty Suicide Deaths 2003-09	Active Duty Suicide Deaths 2009	2009 Difference from Army Demographic
Gender: Male	86.6%	94.4%	96.9%	+10.3%
Age	23	21	23	0
Race: Caucasian	62.7%	74.3%	76.7%	+14.0%
Marital Status: Married	58.0%	52.1%	48.5%	-9.5%
Rank: Jr. Enlisted	45.5%	57.1%	58.3%	+12.8%
Career Field: Infantry	13.2%	20.7%	23.9%	+10.7%
Component: AC	77.0%	83.3%	89.0%	+12.0%
Deployment History: One or more	70.9%	69.3%	68.7%	-2.2%

Chapter Summary

As discussed herein, the demographic profile of the Army is changing to include more women, Hispanics, and Asian-Americas—all of whom, like their Caucasian and Black counterparts, have the potential to be exposed to highly stressful combat and non-combat situations. What roles do race and gender play, if any, when addressing the Army efforts to reduce suicide among all personnel? What does the fact that the Army 2010 Report did not identify a specific breakdown of suicide based on gender and race say

about how it should target its efforts? In the case of race, it could be that the Army's view on a more intense study of race and suicide reflects what some have found—namely that studying race, and in-particular African Americans and suicide, has simply not been done to the degree it should be.

CHAPTER 6

FINDINGS AND DISCUSSION, SUMMARY, AND RECOMMENDATIONS

Introduction

This chapter presents the empirical results of this study. The first section assesses the association between suicide and the US Army with a focus on the findings associated with labeling theory (*Part A*) and with a race/gender construct (*Part B).* The second section of this chapter discusses the summary of my research goal with respect to the interplay of suicide, bureaucracy and the US Army. This chapter then concludes with recommendations.

Why study the Army? First, we are reminded that the Army is the largest military organization in the United States; second, the Army as an institution has a longstanding history of leadership; and third, as a branch of the United States military, the Army is part of an inimitable environment. Studying the Army is beneficial not only for understanding that single (although complex) organization—but this study is also expected to elucidate the concerns and protocols of the other American military organizations in terms of how they are grappling with similar issues in their own ranks.

Section I: Findings and Discussion

Suicide: Labeling the Cause; Suicide Gender and Race Neutral/Specific

Part A. Suicide: Labeling the Cause

Part A interprets the data described in Chapter 4 of my study and relates it to Schur's labeling theory, which was introduced in Chapter 1 and reviewed further in Chapter 2. Labeling theory has its origins in studies of deviance. While some sociologists have varying opinions when it comes to what constitutes the concept of deviance, this study addresses the labeling process and appropriately includes a discussion of deviance at it pertains to the topic of suicide and the US Army. One might argue that an examination of the Army and the bureaucratic processes it uses to address suicide is, in itself, an unusual case for labeling theory. However, the issue is not whether a suicide was committed and can be identified as a deviant act—but rather the reason(s) behind such a deviant act and the role/interpretation that bureaucracy plays within and outside of this act. Anne Hendershott's *Politics of Deviance* (2003) reminds us that suicide has justifiably been viewed as a deviant act because it corresponds to the extreme devaluing of a human life. In studying suicide, the Army, and Schur's labeling theory, I have reviewed the following concepts in seeking to understand how they interconnect: *organizational processing, organizational imperatives, retrospective interpretation, moral entrepreneurship,* and *stigma*.

Organizational Processing:

The United States Army describes itself as an organization with a unique structure and a focus on one goal—to fight and win our nation wars. The structure of the Army

results in specialized organizations that perform certain roles, functions and missions, all directed toward the main goal. The distinctions within the Army's regulations and reporting structure all work toward shaping and defining the way the Army identifies what takes place within their daily operation, which ultimately contributes to the mission of taking care of soldiers. According to Schur, *organizational processing* within an organization can produce deviants. Schur clarifies this argument further by stating that not all deviants are produced by an organization. How does this concept apply to the US Army, soldiers, and suicide? \

Post 9/11, the Army—like most military branches—widened their definition of types of service men and women qualified or "fit" to serve in the United States military. The following speaks to the all-volunteer Army and the role that may play with respect to deviance and an increased risk of suicide among Army personnel:

> It is often said that the Army is a "microcosm of society." In an era of an all-volunteer Army, however, this is not exactly true. The demographics of the Army do not realistically reflect the society as a whole. While it is true that individuals in the Army are not immune to overall societal pressures and influences, we should be cognizant of the individuals who now "self-select" and drive the makeup of the all-volunteer Army. These criteria are communicated and set by policy based on clear standards of conduct. By not fully complying with established policy, commanders are in fact communicating to their troops that Army standards of conduct are less important in the scope of the overall mission. (Army Report, p. 60)

In contemplating this description, one might question whether standards have been lowered and/or changed in order to allow a wider range, and therefore a greater number, of individuals into the Army. In other words, individuals who in the past may not have been considered qualified for Army service are now being admitted into the organization—and may be bringing with them undesirable issues/behaviors. The Army is

not unaware of this dilemma, as reflected in the AR 15-6, which is a screening tool used by the Army to identify and investigate behavior. The AR 15-6 (aka "Procedures for Investigating Officers and Boards of Officers") instigates an investigation that can be formal or informal, the results of which may play a significant role in the labeling process of a soldier either while he is serving or once he resigns or is discharged.

Investigative Questions

The reasons involved in labeling a suicide as deviant behavior—and an action that a *good* soldier simply would not do—can be found in the line of questions identified in Chapter 4: *The Bureaucratic Process of Making Sense of Suicide*. Table 1 in Chapter 4 is divided into the following four categories (captured in detail in Chapter 4).

1). *Communication of Suicidal Intent:* Addressing gaps in policies, processes and programs; behavioral health issues; suicidal threats; level and degree of communicative circumstances surrounding suicide.

2). *Personality and Lifestyle*: Addressing soldiers personality; demeanor and normal (changed) behavior; mental illness and/or health problems; gambling, relationship and/or financial issues.

3). *Military History:* Addressing military justice issues; unfavorable personnel issues; counseling; suicide prevention and resiliency training; overseas tours of duty.

4). *Other:* Addressing what others think/thought of the soldier; singled out for harassment.

Although fairly comprehensive, the questions asked during the investigative process (outlined within the above four categories) may generate different

responses/information depending on the investigative officer. In other words, the assigned offer may infer a finding that was not "expected," which could then place the soldier in a bad light—ultimately causing the investigator and others to view the soldier in a different way.

Organizational Imperatives:

Schur defined *organizational imperatives* as organizational rules/regulations that are intended to support the organization by preventing negative outcomes. However, in some cases these organizational imperatives could have unintended consequences if they end up actually promoting, reinforcing, or encouraging certain negative behaviors within an organization. In the case of the Army, the *organizational imperatives* that are in place are overwhelmingly designed to maintain the status quo—to continue traditions of discipline, readiness, cohesiveness, and responsibility (among others).

The Army is organized the way they're accustomed to being organized—*running things the way they've always run things.* Therefore, there needs to be available explanations and rules/regulations in place in order to assist soldiers within the organization according to their needs, some of which challenge available support systems. Ideally, these directives should protect the soldier, reinforce the mission, but not rock the boat too discernibly. Can the Army continue to operate the way they've done in the past as they work toward understanding suicide? In other words, in today's environment how acceptable are expressions that are increasingly heard by soldiers, such as "combat stress," "disillusionment with war," "guilt for participating in war," or other similar indications of dissatisfaction. This is a question that the Army cannot avoid

answering. The documents described in Chapter 4, which are intended to help explain a soldier's suicide, are important in this process as they not only determine whether the death results from suicide, but also identify the circumstances and explanations applicable as part of a soldier's death. Rules and regulations define and will continue to define the Army; in fact, the AR 15-6 is another indication that the Army is doing things the way it's regulated to be done. The AR 15-6 and subsequent reports assist in a process aimed at understanding and combating suicide.

One of the imperatives for an organization's vision is that it should be based on, and consistent with, the core values of the organization. The Army has seven core values: *loyalty*, *duty*, *respect*, *selfless service*, *honor*, *integrity* and *personal courage.* Core values are taught during basic training and soldiers are expected to internalize them and integrate them in everything they do—on or off post. Therefore, when a soldier chooses suicide to end his/her life, that soldier is violating one or more of the Army's seven core values. Such an action can understandably be viewed as deviating from the Army's norm.

Stigma

Schur (1971) described stigma as something that deviates from what society sees as normal. Moreover, he argued that when individuals or groups engage in deviant behavior they are involved in a social process he characterized as negotiation, bargaining, power, and at times, resistance. Schur then described how society typically responds to "deviants"—namely, with …interpersonal or collective reactions that serve to 'isolate' 'treat,' 'correct,' or 'punish' individuals engaged in such behaviour" (1971: 24). Goffman (1963) used the term stigma in connection with an attribute that can either be physical

(e.g., a deformity) or behavioral—which another individual then responds to in one of the ways Schur listed (above)—all of which the author believed to be deeply discrediting.

Schur reminds us that behaviors considered to be deviant, and therefore subject to being stigmatized, tend to vary considerably between cultures and as well as over time. Within the military culture, Army leaders have painted stigma as a perception among leaders and soldiers that if one seeks behavioral or medical help, it will be considered detrimental to a soldier's career or could marginalize the individual.

> The Army vice chief of staff, told public health officers that he hopes the "seek help" message will encourage soldiers to overcome the longtime stigma of behavioral healthcare. But the Vice acknowledged that military culture has a long way to go before attitudes toward mental health shift. Indeed, speaking out about one's pain—psychic or physical—goes against an entrenched military culture of stoicism. Service members are supposed to suck it up without a word of complaint, lest they be labeled weak or suffer a career setback.[45]

The above excerpt indicates that the problem of *stigma* is a significant concern for the Army since in the present Army environment, the notion of admitting the need for help still involves stigma and labeling. Army personnel across all ranks need to reassure their comrades that psychological stress needs to be addressed immediately, especially when suicidal behavior is indicated. Similarly, the Army needs to promulgate an environment whereby "deviant Army behavior" (e.g., weakness, suicidal intentions) can be destigmatized—if not, those who need help will not seek it out. In other words, the Army needs to reassure its members that it is socially and professionally acceptable to seek help. Indeed, empowering soldiers to trust that it is totally acceptable to seek help should become a top priority of the Army if it is to reduce the incidence of suicide. Fortunately,

[45] http://articles.latimes.com/2010/oct/13/opinion/la-oe-buckholtz-military-suicides-20101013/2

the 2010 Army report indicated that even though the stigma associated with seeking behavioral healthcare treatment remains a problem in the military, there is evidence that the current anti-stigma communications campaign is improving perceptions.

Retrospective Interpretation

Using information submitted as a case study or a case record to review a suicide represents what Schur labeled as *retrospective interpretation - viewing deviators or suspected deviators* in a *totally new light*. As a process undertaken after the event, the Army engages in *retrospective interpretation* through their review of suicide summary reports, as well as other subsequently-obtained information documenting the soldier's death. These reports discuss the how, when, where and any other factors that may have contributed to the soldier's death. Once the information is synthesized, those involved produced a suggested "why" finding, such as the following: *To maintain situational awareness, the VCSA received monthly briefs regarding the facts of every suicide within the Army. These briefings revealed that the soldiers who ultimately take their lives have typically been engaging in high risk behavior long before their tragic end. Senior Army leaders intuitively recognized the problem was the result of atrophied garrison leadership skills* (Army 2010 Report: 55).

> ……some of the best information the Army has comes from the individual case studies discussed at the monthly Pentagon conference. Before the meeting ended, the VICE pressed his field commanders and fellow Pentagon generals to make sure that the lessons from the 12 cases they had studied that day made their way out into the force at times, Army leaders were frustrated by cases that defied simple explanation. In other instances, soldiers simply fell through the cracks.

> Monthly meetings are the Army's way of sleuthing out patterns and identifying new policies to deal with the trend…[46]

Prior to his or her death, the deceased was a soldier—someone with stature and a position that was part of the total Army. Indeed, the very fact that the person held a rank/grade upheld his/her status as a member of the Army. Post suicide, however, the circumstances change. Although still accorded a soldier's respect, implications could be made that question the deceased's military commitment, purpose, beliefs—not to mention any or all of those key Army values (*loyalty*, *duty*, *respect, selfless service, honor, integrity* and *personal courage).*

When using the labeling approach in the analysis of a soldier's death, one must reconstitute the individual's character or identity. This process produces a *retrospective interpretation* of the soldier, as exemplified below.

> A recently arrived (6 month) soldier with an exemplary 10 year career; supervisor and commanders recognized soldier as "top" notch. Happily married, participated in the Army sports teams and coached both sons little league teams. Soldier had two previous overseas deployments with the last deployment two years earlier. Soldier found hanging – death result of a suicide. Investigation conducted. Commander briefs the soldier's death and spoke about soldier's conversation with fellow soldiers and feelings soldier encountered with the transition to his new unit. [47]

This approach includes an interpretation of deviance, which necessitates a significant amount of time to sift through case records or case histories. The Army post-suicide report attempts to paint as complete a picture as possible of the soldier up until and leading to his/her death; this report uses less complicated documentation with specific

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[46] http://www.spokesman.com/stories/2009/may/24/military-suicides-a-vexing-enemy/

[47] Example of factors involved in a soldier' suicide death and the next steps.

information that speak to the soldier. Nonetheless, no matter how the facts are captured and presented, they all too often may lead examiners to view the soldier as deviant.

By analyzing medical cases, Goffman (1961) determined that the rationale for employing actual case histories is not only to identify, support and reinforce a diagnosis—but also to help "bring the patient to life" in the mind of the physician. In a military setting, the use of case histories helps examiners understand and interpret the circumstances surrounding the soldier's suicide. The soldier now has what Goffman described as a *new view,* one that other soldiers and/or investigators may not have ever considered or connected with the soldier before his/her death.

When a *retrospective interpretation* used during a post-suicide review results in a unfavorable depiction of a soldier, it is comparable to what Schur labeled as *stereotyping* the deceased. However, the term *retrospective interpretation* is difficult to intellectualize—in fact, the translation in itself is difficult. It is important to remember that as Army officers brief their higher-ups on the unfortunate fate of their soldier(s), they also have to account for and understand why a soldier would choose to take his/her life. All this is happening at the same time that the leader is responsible for a unit/brigade/squadron etc., possibly involved in an active combat situation, but who is also a member of a huge military bureaucracy that lives by, in most cases, "dated" rules and regulations. In short, the entire process is difficult and challenging. It is a process that no single leader wants to take on; however, at the same time it is a process that combines what the soldier's chain of command can use to, in some cases, explain and/or perhaps justify what they believe ultimately prompted the soldier's suicide—making it an essential activity. In essence, although the process may end up stereotyping the soldier, it

is all part of what labeling describes as that *new light* when it comes to revealing all that surrounds the death.

Moral Entrepreneurship

All too often, rules tend to be enforced only when something provokes enforcement, which then leads someone to actually take the initiative. This enforcement becomes an enterprising act, which according to Schur (1971) requires *moral entrepreneurship.* In terms of the Army's response to suicide, Army leadership has taken the initiative as evidenced by a set goal of enforcing others to find the answer (or more likely, answers) that ultimately reduces the incidence of suicide in its ranks. A corollary benefit is that it will ultimately transform the public attitude that the Army may not be doing enough to address this grievous issue. This proactive initiative is reflected in the fact that the Army has encouraged the media's involvement in a variety of venues once it became clear that suicide was on the rise. Specifically, media are invited to Army reviews and update sessions with the goal that they will get the message out that Army leaders are doing what they can with available resources to reduce the incidence of suicide. For some, the rise in suicide has created a moment of *moral entrepreneurship* for those commanders who maintain that under *their* leadership there's been significant progress in reducing suicide. In some cases, actually, careers may have been advanced by being a part of and/or participating in the efforts to minimize the Army's suicide numbers. .

PART B: Suicide – Gender and Race Neutral or Specific

Part B interprets the data described in Chapter 5 of my study and relates it to a race and gender construct, which are concepts introduced in Chapter 1 and subsequently

discussed further in Chapter 2. Johnson (2000) reminds us that everyone has a race and gender background. And similar to the wider population, the military is no different when it comes to the prevalence of racism and all other "isms" that affect us all; in other words, they are not limited to women and/or certain minorities.

Lynn Weber (2001) spoke to the notion of race and gender (social constructs) as complex oppressed social systems—and that race and gender combined have the potential to double the risk of oppression, even as a person contemplates suicide. There is consistent change within both these variables—change recognized not only on a personal identity level, but also at a social institution level. While researchers have documented that race is one of the most understudied basic demographic variables when it comes to suicide (Lester, 1992; Stack, 1982), Max Weber viewed the notion of gender as a concept of patriarchy, which he described as one of the oldest forms of social legitimized power (Jackson & Scott, 2002). Both these findings in race and gender are equally true as one assesses the result of the 2010 Army report.

As discussed earlier, the Army is the largest military organization in the United States and by far the one with the most diversity in personnel. As noted in Chapter 5, there has been an increase in racial and ethnic diversity in the Army over the past couple of decades, which has resulted from the massive recruiting effort of the Army. Additionally, the DoD has become more successful toward developing an all-volunteer Army—and this is related to economic issues, better military pay, manpower numbers, recruiting/advertising, managing a soldier's future occupation, as well as other factors (Fredland, Gilroy, Little & Sellman, 1996). Fredland et al. noted that the DoD is not only committed to providing a supportive environment for its service members in hopes of

them staying in the military, but also expects them to be "ambassadors" of military life both in and out of uniform. These efforts have attracted recruits from every walk of life. Thus, one could expect that the same approaches for reducing suicide in the general population would be applicable to military settings as well, since the two demographics are become more similar.

For a sociologist, the cause(s) of suicide has nothing to do with the actual act of death—i.e., the means one uses to "self-destruct." Instead, the real causes reside in the social structure, norms and beliefs of the culture (Hendershott, 2003). Hendershott echoed Emile Durkheim when reinforcing that suicide is rooted less in the mind of the suicide victim than it is in the mind of the group, in group values. In other words, the decision to commit suicide is linked to more to the coercive power of society and has less to do with individual will—although the latter certainly plays a part. Durkheim (1951) argued in *Suicide* that values, attitudes and beliefs about suicide may appear to be individually constructed; however, he asserted that collective forces actually guide a person toward self-destruction. Analogously, because the Army is such a "total" and dynamic institution, it represents an exceptionally strong force when it comes to governing the life of a soldier—as well as the soldier's family members—and should not be discounted when looking at the phenomenon of a military suicide.

Scholar W.E.B DU Bois had this to say: *We are all American, not only by birth and by citizenship, but by our political ideals, our language, our religion. However, further than that, our Americanism does not go.* He then added, *African Americans are members of a vast historical race; therefore, it is their duty to conserve spiritual ideals; strive by race organization, solidarity and unity – to the degree it recognizes differences*

in men, but depreciates inequality in the opportunities of development (Peter Kivisto; 2003: 161). This statement is compelling when applied to the way the Army has studied suicide in terms of race, and in some cases, gender.

Gender and Race Discussion

Gender Differences

We identified early on that in terms of suicide attempts, they are more common among females than among males.[48] With respect to Army suicide numbers, the 2010 report shows a gender distribution of 151 males versus 9 females (see Table 9). Moreover, males have a much higher rate of success in suicide than females among all ages around the world. One of the most commonly reported differences in male and female suicide behavior is suicide method. Men tend to choose more violent methods (e.g., guns, hangings), while women choose methods that are less violent, such as overdosing. At the same time, West and Zimmerman (1987) found it necessary to move past the notion of gender to consider "doing gender." These scholars asserted that the "doing" of gender is undertaken by women and men whose competence as members of society is hostage to its production. Doing gender involves a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine "natures." (West & Zimmerman 1987: 126)

> The gender stereotype of men being "tough" and "strong" does not allow for failure, perhaps causing men to select a more violent and lethal method of suicide; while women, who are allowed (in social acceptance terms) the option to express weakness and ask for help, may use suicide attempts as a

[48] With the exception of China; more females die as a result of suicide and/or the level is equal between men and women.

> means of expressing their desire for assistance. Experts suggest that gender might also influence what methods a person is familiar with or has ready access to. For example, men are generally more likely than women to be familiar with firearms and use them in their daily lives, and thus they might choose this method more often. Suicide attempts should always be taken seriously and not dismissed as attention seeking behavior, nor should it be assumed that only persons of a particular gender will use any given method Schimelpfening (Sept 1, 2011)

In *Are There Gender Differences in Suicides Methods,* Schimelpfening (2011) suggested that gender does indeed influence the suicide method a person uses. Whether this finding has to do with familiarity with available choices or access to guns, it is important to note that although Army men and women *both* have access to guns *equally*, military women still choose other means of ending their lives.

Racial Differences

It is evident that there has been very little attention to the subject of African Americans and suicide (Gibbs, 1997; Joe & Kaplan, 2001; Lester, 1998). This is also palpable throughout the Army's 2010 report, which identifies the average suicide "victim" as a 23-year old Caucasian American. The 2010 report does not, however, discuss how other races fit into this "average" definition—but this study does parallel outside findings. This is not to suggest that the Army does not have figures that delineate available findings when it comes to African Americans and/or other races with respect to suicide. In fact, as shown in Table 9, the Army's DoD DODSER report (2011) has current figures (2008–2010) for suicide. The numbers in this report indicate that there is a high percentage of suicide by Caucasians, and more specifically among Caucasian males. This table also shown that suicide rates have been on the rise in the years prior to 2010, as researched and introduced during Chapter 1 of this study.

Table 9. CY 2010 AFMES and DMDC Demographic Data and Rates for Army Suicide

		2010				2009	2008
		Count	Percent	DoD Total Percent	Rate/100K	(N=166) Percent	(N=140) Percent
Total		160	100%	100%	21.72	100%	100%
Gender	Male	151	94.38%	86.00%	23.84	97.59%	94.29%
	Female	9	5.63%	14.00%	*	2.41%	5.71%
Race	American Indian or Alaskan Native	4	2.50%	0.79%	*	2.41%	0.71%
	Asian or Pacific Islander	11	6.88%	3.53%	*	6.63%	5.00%
	Black/African American	20	12.50%	19.33%	14.05	11.45%	14.29%
	White/Caucasian	125	78.13%	70.95%	23.92	79.52%	77.86%
	Other/Don't Know	0	0.00%	5.40%	*	0.00%	4.29%

N = 160

from DODSER 2011 Report

Marcus (1996) found that as a result of discrimination, poverty, family disintegration, and the belief that Black men tend to face more stresses than their White counterparts, Black men are better equipped to deal with inevitable challenges and disappointments in life. This could also be true for African American soldiers. Because

they have tended to face more social and economic hardships, they may be better prepared for the stresses associated with military life—making suicide a less palatable choice for the Black soldier.

Washington, D.C., the nation's capital, has had the lowest rate of suicide for well over a decade. As shown in Table 6 (Chapter 5), the Northeast has the lowest suicide percentage among national geographical regions. While Durkheim would have connected this to a history of shared oppression amongst African Americans, some may view suicide and homicide as linked. In other words, one oppression results in suicide, and the other oppression results in homicide. Using Durkheim's theory, it would be difficult to discern which reasoning is more accurate.[49] The social integration within the African American community normally does not allow for high suicide rates amongst African Americans.

Gibbs (1997) identified five domains associated with the reduced suicide rate among African Americans: 1) strong religion base; 2) courage and resilience of Black women in nurturing their families and building their communities; 3) the importance of elders in the community where they are treated with respect, in contrast to White elderly Americans who are more likely to be placed in nursing home; 4) extended family, which provides a sense of identity, security and support while providing a buffer between the member and family; and (5) the external and cohesive social environment that reinforce extended families. These very domains are similar to the influences that the majority of

[49] While this research does not focus on Durkheim and his important discovery of the theory of suicide; the author does recognize his contribution to where the sociological study of suicide is today; and therefore, further research and findings in terms of suicide and the lack of sociological references within the Army 2010 report will be explored in future research.

African American/Black soldiers bring with them to the military, and which support them when faced with the various stresses associated with life as a solider. In essence, it is what they have grown from and lived with well before entering the Army. That these domains have been effective/successful seem to be reflected in the number of suicide deaths among African American/Black soldiers compared to White soldiers. It is important to note that enlistment numbers among African Americans has been on the decrease. Yes even with the large population of African Americans still serving in the Army, the suicide numbers remain disproportionately low.

The suicidal behavior among Whites and Blacks has had more attention in comparison to Hispanics (Burr, Hartman, and Matteson 1999; Gibbs 1997; Kubrin, Wadsworth, and DiPietro 2006; South 1984; Stack 1996). These authors identified the following key issues critical toward developing a sociological perspective:

- ✓ At least 50% of U.S. Hispanics are immigrants; therefore studying this population allows researchers to consider the effects of immigration and cultural assimilation on suicide. These processes have significant implications for social integration—a key factor noted by Durkheim (1951) and others in suicide literature.
- ✓ Hispanic economic mobility have been similar to that of blacks and other minority groups, yet Hispanics experience different patterns of immigration, assimilation, and labor market participation; raising the question of whether economic disadvantage and inequality impact suicide rates for Hispanics as it does for other groups
- ✓ Hispanics have low suicide rates, often less than half those of whites (Goldston, 1988), As with researching suicide among blacks—another group with low rates—studying Hispanics is critical for understanding the culturally or ethnically based protective factors that deter suicide.

Although the number of Hispanics nationally has been on the increase over the past decade or so, they are still underrepresented as a percentage of soldiers in the military. This group is also second within the Army population in terms of the lowest

number of suicides. Comparable to the Black community, Hispanic suicides are proportionally far lower than White suicides. Also similar to the Black community, Hispanics tend to be more socially integrated and have strong family ties. Additionally, Hispanics are more apt to have steady jobs. Martinez (2002) argued that "attachments to the world of work even through subsistence-paying jobs are part of the bond that fortifies Latino communities and helps them absorb the shock of widespread poverty" (p. 133). Although this study did not produce a great deal of research on Hispanics and suicides to include significant findings within the Army, Martinez found that Hispanics tended to experience lower rates of family disruption and other social ills, which suggests that impoverished Hispanics are more socially integrated than otherwise might be the case. Martinez suggests that "traditional economic explanations" may be less applicable for understanding and explaining suicide among the Hispanic population.

In contrast, even though the wider Asian population (Chinese, Japanese, Koreans, Vietnamese, Indians, Pakistanis) show low numbers when it comes to suicide, Army soldiers of Asian descent seem to have higher suicide rates than other racial groups within the Army…in fact, their risk is double or triple that of other soldiers, and even higher during times of war—four times higher.[50]

African American Women and Suicide

Gibbs (1998) reported that Black women attempt suicide just as frequently as White women—but are less "successful," meaning they actually die in lower numbers.

[50] http://www.veteransforcommonsense.org/index.php/national-security/2217-gregg-zoroya; a Mar 2011 article indicates that Asian females as having an even higher rate of suicide during war – article does not specify "why".

This statistic has not changed as evident by the latest CDC (2007) findings. Additionally, African American female attempts do not compare to the number of AA males and/or females in general that die by suicide. In considering these statistics, Gibbs described the buffers that surround African American women (e.g., extended families, religious views, and strong maternal upbringing) and labeled them as effective support system(s) when it comes to suicide. Even more central to lower incidence of Black suicide is the general belief that suicide is unacceptable in the African American culture.

In discussing the historical suppression of the ideas, knowledge, and lived experiences of Black women, Patricia Hill Collins (2000) suggested that they are not just affected by one form of oppression, but many forms—making Black feminist thought necessary. Collins also described the interconnected oppressions of gender and race, a matrix of domination that allows dominant groups to exercise power and manipulate the ideas of Black womanhood (Collins 2000: 68). When such oppression takes place, women of color may then be identified as a subordinate group to most. Despite this identification, the suicide statistics included in Chapter 5 reveal that Black women have the lowest level of suicide in the Army—regardless of being doubly "challenged" by race and gender. A 2011 study by Army STARRS[51] elaborated further on the suicide rate of women at war. Even though male suicides are *higher* before, during and after deployments, female suicide numbers continue to be much *higher* in war zones, although they are generally lower across the boards. The Army attributed the increased suicide risk for deployed female soldiers to missing their families and a lack of their support systems.

[51] Army STARRS Preliminary Data Reveal Some Potential Predictive Factors for Suicide" is posted at www.nimh.nih.gov/science-news/2011/army-starrs-preliminary-data-reveal-some-potential-predictive-factors-for-suicide.shtml

In sum, race and gender are structured interactions, opportunities, consciousness, ideology and forms of resistance that not only characterize American life, but also indelibly shape life in the military.

Section II: Summary and Recommendations

Part A: Summary

American military leadership is showing just how bureaucratic the modern United States Army is as they fight to bring down the incidence of suicide. Weber described the military as *bureaucratized due to the obligation and the right to serve in the military which were being transferred from the propertied to those without property*, which remains a criticism of the all-volunteer force (Segal:47). Weber also felt that emerging military technologies would necessitate the growth of military bureaucracies. How this bureaucracy affects Army leadership as they work toward reducing suicide numbers is an issue—which is compounded by the fact that some in leadership positions may not be fully aware of the hampering effect of the Army's bureaucratic environment:

> The Army's response is typical for any bureaucracy: collect the statistics, slice them up, and tabulate them in a recurring report. Regrettably, on the matter of suicides the Army's bureaucratic response is misguided. http://smallwarsjournal.com/blog/armys-suicide-watch-report-is-spineless

> The Army's monthly suicide watch" report reflects a bureaucracy entirely on the defensive. It is disrespectful to the slain soldiers and ratifies a false narrative about military service. Most tellingly, it shows an Army leadership un-to defend its institution. http://smallwarsjournal.com/blog/armys-suicide-watch-report-is-spineless

> Hundreds of pages of documents the soldier's family obtained and shared with the Associated Press after battling a military bureaucracy they feel didn't want to answer their questions, http://www.msnbc.msn.com/id/22332372/ns/us_news-military

According to Marcus (2003), out of every ten people who kill themselves, eight (i.e., 80%) communicate definite warnings of their suicidal intentions. Moreover, many people who actually commit suicide do so by impulse, with no advance planning. Demonstrating a much lower percentage of suicidal intentions, only a third of the Army soldiers who die as a result of suicide told someone of their plans to die (Sept 2011 release by the DoD):

> Nearly half went to see medical personnel, behavioral health specialists, chaplains or other service providers sometime in the 90 days before they died. That doesn't necessarily reflect a failure in the Defense Department suicide prevention program, said chief of the Suicide Prevention Branch at the federal Substance Abuse /Mental Health Services Administration. "It's not that some person blew it" (Dan, Elliott, AP; Sep 2011).

Expressed throughout the 2010 Army report—as well as captured through a number of media examinations, and/or in some cases identified through *retrospective interpretation* of suicidal deaths—the Army believes that military conduct has eroded and they now see what they describe as dangerous trends in behavior. Specifically, they point to soldiers who are likely to abuse drugs and alcohol, or engage in increased levels of high risk/criminal activity, which could have a negative impact on suicide levels within the Army. There are a number of tables and figures within the 2010 report (i.e., Tables 6, 7, 8, 9, 10, 22, 23; and Figures 10,13,14,15, 16, 19, 21, 23 and 76) that document the drug abuse and high risk behaviors of soldiers. It is important to note that the report also indicated that data collected since 2005 consistently showed that approximately 29% of suicides involved soldiers who experience either drug or alcohol use, and 25% of suicide victims were involved in either closed or pending criminal investigations. While the report doesn't specify

race and/or gender as an area of concern, the Army should not lose sight of these variables as they build toward integrating and lowering the incidence of suicide.

The Army continues to look for the answers; yet bureaucratically there continues to be obstacles. The 2010 report resulted from an 18-month study that from the beginning addressed over 200 tasks—all aimed at addressing suicide. Subsequent to the report's release, over 300 tasks resulted that were to be addressed over an additional year or so. The vignettes described in Chapter 3 identify the real-life concerns of Army soldiers and in some cases leaders, which are categorized throughout the report. The Army recommended that the 34-line report be revised, and the resulting 37-line report is currently awaiting approval. In a nutshell, the revised report (according to the Army) is more comprehensive and has been reconfigured in order to address more questions. The revision is expected to assist investigative sources as they gather information about a soldier's situation prior to suicide.

Implications of the Findings

Based upon the findings of this study and corroborated in the Army's 2010 report, the Army's *institutional policies, processes, and programs have not kept pace with changes resulting from nearly a decade at war and the simultaneous efforts of Army Transformation*. This, the Army refer to as *"the Lost Art of Garrison Leadership."* The Army also admitted to a lack of situational awareness and no good order of discipline in the ranks (Report; 2010). In other words, in such instances they appear, in their vernacular, to have "lost the bubble."

The 2010 report identified a number of policies and recommended changes to the Army, each of which the Army is reported to either have put in place or are currently addressing. The Army is aware that there are problems; however, they seem to fail to recognize (at least publicly) that institutional bureaucracy may have a role in holding up the process. Soldiers join the military for various reasons, but few really have a grasp of what that will entail, what they will be asked to do, and what the organization looks like from within. Drawing from Max Weber's explanation of bureaucracy as "a form of an organization of rational-legal authority . . . characterized as a continuous organization bound by rules and in a specific area of competence and hierarchy," it is clear that the Army faces an uphill battle if it is to maintain a successful fighting force, while at the same time coping with the behavioral deficits and emotional stresses that are becoming increasingly commonplace among its members.

Part B: Directions for Further Research

In terms of providing the Army some direction in addressing suicide—while keeping in mind the internal bureaucracy that characterizes this organization—the following recommendations are suggested: (1) conduct an external study of soldiers and suicide, (2) conduct an *in-depth* study of suicide with a focus on the roles of race and gender, and (3) review the Army's effectiveness in today's culture in terms of current policy, focusing on race, gender and bureaucracy.

Recommendation #1: Conduct an external study of soldiers and suicide.

How effective would a study of suicide and the soldier be? I argue that it depends on *who* is conducting the study. First, one must first examine current suicide statistics.

Every 40 seconds someone dies from suicide. With research showing that more than a million people a year worldwide commit suicide (including 30,000 Americans), how do Army suicides compare? As shown in Table 10, total Army suicides have been increasing.

Table 10. Number and Rate Per 100,000 Person/Years of Suicides Involving U.S. Army Soldiers.

Army Suicides	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total	52	70	79	67	87	102	115	140	162
Active Duty	47	55	62	54	63	88	93	119	146
Reserve/National Guard	5	15	17	13	24	14	22	21	16
Army Suicide Rate per 100,000									
Total	9.0	11.5	11.4	9.6	12.7	15.3	16.8	20.2	21.9
Active Duty Army	9.8	11.3	12.4	10.8	12.8	17.2	18.1	22.2	--
Reserve/National Guard	5.3	12.4	8.7	6.4	12.4	9.3	14.4	13.6	--

Note. Data obtained from Army and National Vital Statistics System. (—) = rate not available.

It should also be noted that the 2010 report made issue of the fact that there is an *alarming rise of soldiers who engage in high risk behavior*. This is linked to what the Army classified as a strained Army—recruiting and retaining individuals that may not have been qualified to serve in the Army in the past. The Army is aware of this; they are also aware that Army service entails significant financial hardship, relationship strains, and mental health challenges—not to mention serious physical risks. Although I am convinced of the Army's dedication to reducing the incidence of suicide, I am not

persuaded, given the bureaucratic challenges discussed herein, that an internal study is sufficient. Rather, I recommend that an extensive, external study of the problem be conducted with all available resources, which could then be submitted to senior Army personnel for their consideration.

Durkheim (1896) was the first to tell us that every society has a definite aptitude for suicide, and that each society is predisposed to contribute a definite quota of voluntary deaths. Yet Durkheim and Joiner (2005), not to mention countless other scholars, have yet to identify "proof positive" when it comes to a rationale for suicide. With the amount of resources the Army has currently engaged in this investigation, those seeking answers in order to reduce Army suicides will continue to face a formidable bureaucracy that will inevitably interfere with this process. Although the Army admits that more information on the phenomenon is needed, Army leadership needs to eliminate as many roadblocks as possible so that an external study of suicide and the soldier can be carried out.

Recommendation #2: Conduct an *in-depth* study of suicide that emphasizes the roles of race and gender.

The researcher recommends an in-depth, sociological study of the role of race and gender as each relate to military suicides across the entire system—in short, considering the constraints and triumphs of all the military branches with respect to these two variables. When it comes to suicide, Lester (1992) and Stack (1982) reminded us that race has been one of the most understudied basic demographic variables. Given the ongoing changes within organizations, race and gender must inevitably come into play in terms of organizational practices and beliefs (Weber, 2001). Interestingly, the Army's

2010 report does not define or discuss racial and/or gender statistics in terms of what they are and/or why they're not mentioned. For example, a soldier who took his life was defined as "a 23 year old Caucasian." This study does not dispute that "White" is not a race; however, the importance of other races was omitted in the Army report. Conducting a study that emphasizes race and gender would bring attention to an area that some seem less than prepared to discuss.

Recommendation #3: Review Army's effectiveness in today's culture in terms of current policy, focusing on race, gender and bureaucracy.

Given the fact that race and gender are playing a greater role in our military institutions, a thorough review of existing Army policies and bureaucratic practices associated with addressing suicide is recommended in order to institute changes that would be more effective in today' culture. We are reminded that bureaucracy *is* the Army. Thus, the ways the Army can be successful and accomplish its mission (i.e., reduce the incidence of suicide among Army personnel) can only be viewed through this lens. The notion that drove this study is how the Army—as an organization characterized by a complex bureaucracy—handles/explains suicide. As suggested earlier organizational changes in the military are shaped by the military mission. The military mission is, then, a part of what Weber (Ritzer & Goodman, 2004) characterized as a continuous organization bound by rules and in a specific area of competence and hierarchy—all of which defines the Army. It is a hierarchical system and it is bureaucratic. In reviewing the 2010 Army report, it does confirm the fact that the Army is reviewing and continues to review its policies and programs as they address the suicide escalation.

The Army has evolved over the years in many positive ways (e.g., promoting more minorities and women to higher-ranking positions)—but the increasing incidence of suicide cannot be considered one of those ways and should not be tolerated. We are reminded as far back as Mead (1934) and his description that an institution tends to be a very complex system, and the individuals within an institution are ultimately what characterize it. Hence, the Army—with "an army of people" that help to define the it—can use the talents and knowledge of its members to work toward adjusting its policy and ensuring that efforts to reduce the incidence of suicide in its ranks are as "bureaucracy-free" as possible.

APPENDIX A

DATA CODEBOOK

Capturing and categorizing the conclusion and recommendations at the end of the Army report was a part of this study. The table identifies the number of the references in the data file, the conclusions and recommendations are listed within the table and the data sources used to identify the information with a quick reference list providing the full name for the acronyms used in the codebook of each data source is identified. The names are in alphabetical order. For a full description of each data source refer to Chapter 3.

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