Chapter 6

HOMICIDE AND SUICIDE IN THE MILITARY

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INTRODUCTION: VIOLENT DEATH

Violent death is a historic by-product of the profession of arms. Killing the opponent's soldiers is not the goal of warfare in and of itself, although inflicting casualties on the enemy is one means of achieving the purpose of war. The objective of combat is to reduce the enemy's ability to wage war and thereby hasten the defeat of his political leadership. Within the military, the job of inflicting casualties is limited to certain specialties; the remainder of the military organization provides support. Even though the proportion of combat to support personnel (the tooth-to-tail ratio) is quite large in favor of the latter, all members of the military learn to kill when they go through basic training, which teaches them basic combat skills and military discipline.

Killing in the military context is bounded by law, treaty, and custom as to time, place, method, and who may be properly targeted as victims. Killing is neither arbitrary nor capricious, and those who would make it so within the military are commonly regarded with disdain by professional soldiers. Murder and suicide are both clearly outside the realm of acceptable military conduct; and although they occur with relative infrequency in the military, each is a significant social problem in its own right. The death of a military member because of homicide or suicide is a tragic personal loss. The victims are denied the richness of a full life; their immediate survivors inherit a bitter residual of shame, anger, guilt, and confusion; and the military loses the productivity of their labor. These deaths are also disruptive to the military in other ways because of the impact they have on morale. Finally, these deaths leave friends and coworkers confused and upset. Violent nonaccidental deaths are also expensive. The direct cost of death benefits and the loss of investment and the cost of replacement make these deaths much more than personal tragedies. This chapter addresses some features of murder and suicide as they occur within the military and explores their respective dynamics.

HOMICIDE

Taking another person's life is arguably the most ancient of crimes. The earliest Judeo-Christian reference to homicide is probably the biblical reference to the death of Abel by Cain in the first book of the Old Testament (Genesis IV:8). The killing of another has historically been a major crime and an inherent wrong in and of itself. There are, however, different kinds of killing, and homicide is a generic term that encompasses a wide range of behaviors, not all of which are unlawful.

The evolution of law is a slow process that reflects emerging sociocultural change. Religion has played a prominent role in shaping behavioral restraints. The Old Testament "eye for an eye" response was softened considerably by the "turn the other cheek" New Testament advice. Legal thinking sanctioned this humane approach by defining criminal behavior as requiring two elements. The *actus rea* and the *mens rea* are the historical vestiges of religion modifying the prosecution of criminal acts. The *actus rea* refers to the physical components of a crime, while the *mens rea* involves the emotional state of the perpetrator. Varying degrees of moral culpability are assigned based on the nature of the perpetrator's mental state. A cold, calculated homicide will ensure a greater social penalty than an accidental, negligent death. Consideration of the *mens rea* in criminal prosecutions is responsible for the introduction of mental health professionals into the courtroom.

According to the Centers for Disease Control (CDC),[1] in 1983, homicide was the 11th leading cause of death in the United States; however, that ranking varied by race and age. It was the fifth leading cause of death among blacks (but the leading cause of death among black males ages 15 to 34 years). Homicide was the 14th leading cause of death among whites.[1] The CDC has identified a number of common patterns in civilian homicides as follows:

- Males are more likely to be homicide victims than females.
- Homicide rates are highest among young adults (with the highest rates among those between 20 and 34 years of age).
- Most homicide victims are killed by firearms (most of which are handguns).

- More than one-half of all homicide victims are killed in the course of an argument or some other nonfelony circumstance, and only a small proportion are killed by assailants perpetrating another crime.
- One-half of all homicide victims know their killers.
- A greater proportion of female homicide victims are killed by family members than male homicide victims; conversely, a greater proportion of male than female homicide victims were killed by acquaintances or strangers.
- Homicide rates are highest in the West.

The most recent law enforcement data on homicide are contained in the Federal Bureau of Investigation's (FBI's) *Uniform Crime Reports* (UCR),[2] which reports that in 1991, the total number of murders in the United States was estimated at 24,703, or 1% of all reported violent crimes. Not only was the number of murders in 1991 high, it rose 4.3% over 1990 and was 8% higher than the 1982 rate. According to the FBI, the overall murder rate in 1990 was 9.8 per 100,000 population (in metropolitan areas it was 11 per 100,000). In 1992, there were 15,377 reported murders involving a firearm. From 1987 through 1992, the number of firearm-related criminal acts increased by 55%. Each year, about 40,000 new firearm reports are added to the previous year's total.[3] UCR data consistently support the CDC findings. For example, in 1990, about 78% of the murder victims were males, and 90% were 18 years of age or older. Almost one-half of the murder victims were black.

Under the Uniform Code of Military Justice, criminal homicides fall into two broad categories: murders and manslaughters, which differ in several ways. Murder, under military law, takes place when a member "unlawfully kills a human being when he (1) has a premeditated design to kill; (2) intends to kill or inflict great bodily harm; or, (3) is engaged in the perpetration or attempted perpetration of burglary, sodomy, rape, robbery, or aggravated assault."[4(p71)] A voluntary manslaughter, on the other hand, is committed when a military member "with an intent to kill or inflict great bodily harm, unlawfully kills a human being in the heat of passion caused by adequate provocation."[4(p74)] An involuntary manslaughter occurs when a military member, without intent to kill or inflict great bodily harm, "unlawfully kills a human being (1) by culpable negligence or (2) while perpetrating or attempting to perpetrate an offense other than a burglary, sodomy, rape, robbery, or aggravated arson."[4(p74)]

The difference between murder and manslaughter lies in intent and circumstances. In assessing the moral culpability of an accused service member, the mental state of the perpetrator is considered. The jury (or panel of members in the military) is given specific instructions by the judge. This legal guidance helps the jury evaluate and weigh the testimony. When one looks at legal distinctions (which are many and complicated), it is easy to overlook the fact that most murders and manslaughters are also human dramas that have antecedent conditions and personal outcomes. Because military members have the same vices, passions, weaknesses, and foibles as their civilian counterparts, it should come as no surprise that some of them also commit murder and manslaughter. The question then becomes whether or not the military context either abets this process or diminishes its likelihood. Unfortunately, there are little systematic data on homicides within the military.

The military community encompasses several features associated with high-risk homicide victimology: it is composed primarily of young adult males, nearly all of whom have been trained in the use of firearms. The military (particularly the army) also has a significant minority population. However, the military is not a random sample of the civilian population. Those who enter the military are screened for physical and mental fitness. They must also meet minimum education requirements, have no significant criminal record, and successfully complete basic training. In other words, the military is a selective environment, and to an undetermined extent, it probably screens out many who would be at high risk as either homicide victims or offenders.

The information that follows, including the case studies, is based on the Headquarters, U.S. Department of the Air Force Office of Special Investigations ongoing analysis of all known homicides involving active duty members of the U.S. Air Force between January 1, 1981, and December 31, 1991. This chapter provides the preliminary disclosure and publication of these statistics. The U.S. Air Force may or may not be representative of the other armed forces, but these finding at least suggest the broad nature of homicides within the military. A word of caution is in order. Although the identification of active duty military homicide victims is simple, information on military offenders is much more problematic. It is easier to count homicide

victims than those who killed them simply because not all homicides are detected and not all logical suspects are identified. Although the data on military offenders are valid, they are probably not exhaustive and must therefore be regarded as representative rather than definitive.

Active Duty Victims

Although the air force homicide victims fell into discrete categories based on legal definitions, a precautionary note is in order. Crimes are both factual and legal events, and the two are not always the same. For example, in reality, a given homicide might actually be a murder but as a matter of prosecutorial convenience be defined by legal authorities as a manslaughter. The air force homicides in this chapter were classed according to their factual nature although they may have subsequently been adjudicated "downward" as something else.

The largest proportion of the homicides were murders, of which 82 (or 70%) were intentional (Table 6–1). The motives for these murders varied; some cases are hard to fathom, while others seem painfully ordinary. For example:

Case Study 1

A 26-year-old civilian went to the residence of a 22-year-old single male E–4 to smoke some marijuana. When the E–4 refused to let him in, the civilian set the house on fire, killing the E–4.

Case Study 2

A 21-year-old single male E–3 was employed off-duty as a part-time clerk in a convenience store. Two males entered one evening and robbed the store. As the E–3 ran after them with a baseball bat, one of the robbers turned and fatally shot him in the chest with a .357 revolver.

Case Study 3

A 21-year-old single male E–3 was living in a trailer with his girlfriend, the daughter of a retired military member. Another resident of the trailer park entered their home one evening and after tying up the E–3, raped his girlfriend. He then forced the girlfriend to watch him while he shot the E–3 in the forehead, and then he killed her as well. The offender was the son of a retired military member and was also suspected of killing five other people. He was sentenced to death.

Nationally, 43% of stranger killings are associated with another crime (usually a robbery). The proportion of military murder victims associated with other crimes was considerably lower: 18%.[2] The low number of robberies involving military victims probably stems from the fact that military facilities are seldom robbed and relatively few military members work off-duty, especially in the kinds of places likely to be robbed. The other category of crime in which a military member is most likely to be a homicide victim is rape, but only 9% of the military murder victims were killed during the course of a rape (4 of the 11 victims were killed during the course of a homosexual rape).

In general, aggravated assault and homicide are similar in many respects, and many homicides are actually "overly successful" assaults. This was clearly the case in many of the military manslaughters. Although they represent a diverse category of violent events, there is a painful consistency among them, as the following cases illustrate:

Case Study 4

A 30-year-old married male E–5 got into an argument in a bar with another patron over a woman. As the argument escalated, the E–5 hit the patron over the head with a beer bottle and then pushed him head-first into the

TABLE 6–1

ACTIVE DUTY AIR FORCE HOMICIDE VICTIMS (1981–1991) BY CATEGORY OF INCIDENT

Category		Number	(%)
Justifiable Homicide		3	(2)
Manslaughter		74	(38)
Vehicular	12		
Involuntary	9		
Voluntary	53		
Murder		117	(60)
Murder	68		
Murder/Suicide	10		
Murder (Terrorist)	4		
Felony Murder	35		
Arson	3		
Rape—Heterosexual	7		
Rape—Homosexual	4		
Robbery	21		
Unknown		1	
Total		195	(100)

bar. The patron became enraged, pulled out a pistol, and shot the E–5.

Case Study 5

After a 39-year-old married male E–5 assaulted his wife, she retreated into her bedroom with their children and locked the door. When the E–5 broke the door down, she shot him in the chest with a .22 rifle.

The average age of military homicide victims was 27 years (which is 6 years lower than the national average for homicide victims); however, averages can be misleading. The lower average age for military victims is probably attributable to the age distribution of the active duty population. As military members reach their early- to midthirties, their numbers diminish rapidly. Among the military homicide victims, a slightly higher proportion was married than single. The marital status of the victims is shown in Table 6–2.

The relationship between the victim and the offender is a critical component in the homicide equation, and Table 6–3 outlines the victim-offender relationships in homicides involving active duty victims. In their study of 508 Detroit homicides, Daly and Wilson[5] found that 25% were committed by relatives, a finding virtually duplicated in the military sample. However, Daly and Wilson further distinguished between genealogical (blood) relatives and affinal (marital) relationships and found that 6.3% of the Detroit homicides involved blood relatives. Among the military victims, 4% were blood relatives. Both findings are consistent with those of Wolfgang,[6] whose analysis of homicides in Philadelphia between 1948 and 1952 revealed that 136 of the 550 (25%) people killed by known assailants were the victims of relatives.

Daly and Wilson's[5] study of homicides in Detroit found that cohabitants who were not blood relatives of the killer were 11 times more likely to be killed than cohabitants who were related by blood and that the principal victims were spouses. This finding is confirmed in the U.S. Air Force homicide study, in which 82.6% of the relatives killed were spouses. It is worth noting that among the military victims, 24 wives killed their military husbands, accounting for over one-half of the homicides by relatives. Women who kill their husbands in society as a whole generally argue that the act was in self-defense against abusive husbands who are threatening either them or their children. The following cases illustrate this point:

TABLE 6–2

ACTIVE DUTY AIR FORCE HOMICIDE VICTIMS (1981–1991) BY MARITAL STATUS OF VICTIM

Status	Males	Females	Total	(%)
Single	74	10	84	(43)
Married	78	21	99	(51)
Separated	6	5		
Not Separated	72	16		
Divorced	9	3	12	(6)
Total	161	34	195	(100)

TABLE 6–3

ACTIVE DUTY AIR FORCE HOMICIDE VICTIMS (1981–1991) VICTIM-OFFENDER RELATIONSHIP

Victim-Offender		Number	(%)
Relatives		46	(24)
Child vs Parent	4		
Husband vs Wife	14		
Wife vs Husband	24		
Other Relative	4		
Intimates		19	(10)
Ex-Husband	1		
Ex-Wife	1		
Lovers	17		
Acquaintances		77	(39)
Acquaintance	12		
Coworker	21		
Date	1		
Friend	19		
Roommate	2		
Sex-Related	16		
Drug-Related	6		
Strangers		52	(27)
Unknown		1	—
Total		195	(100)

Case Study 6

A 33-year-old married (but separated) male E–6 was in his car with his estranged wife (whom he had physically assaulted in the past). As they were discussing their future plans, he became angry and assaulted her. After threatening to kill her, he reached for a gun under the seat, but she pulled hers out of her purse first and shot him four times.

Case Study 7

A 38-year-old married male E–6 had a history of spouse abuse and sexual abuse of his children (in one instance he attempted to drown the female companion of his daughter after she rejected his sexual overtures). He got into a heated argument with his wife during which he told her that he was going to kill her. As he went to get his pistol, she grabbed a .22 rifle and shot him instead.

An important part of the relationship between these victims and their offenders is their connection with the military. Slightly more than one-half of the victims (108 or 55%) were killed by civilians who had no affiliation with the military. Of the remainder, 32 (or 16%) were killed by their own family members, and 49 (or 25%) were killed by other active duty military members. One victim was killed by a retired military member, and in five cases, the affiliation of the killer was not determined. Overall, 42% of the victims were killed by individuals having some affiliation with the military community. In addition, 164 (or 84%) of the military homicide victims were killed off their military reservations and outside the military context. It stands to reason that the killings committed by civilians would take place offbase, and because many of the remainder arose from interpersonal transactions, it was likely that they would also take place offbase (but usually in or near the victim's residence). Not surprisingly, 56 (or 29%) of the killings were sex-related in some way. The majority of the sex-related cases (41 or 73%) involved heterosexual events, and 13 (or 23%) involved homosexual episodes. The age-gender relationship between the victims and their killers is shown in Table 6–4.

Table 6–5 shows the distribution of military victims by their grade. The vast majority (182 or 93%) were enlisted personnel, with the highest proportion (71%) falling between the grades of E–3 and E–5 (corresponding to the 66% of the air force enlisted personnel in grades E–3 to E–5). It is noteworthy that among the officer victims, all 13 were in the bottom-three commissioned grades: second lieutenant (O–1) through captain (O–3). These three grades have 63% of the air force officers.

The majority (161 or 83%) of the victims were males, of which 114 (71%) were white and 46 (29%) black. The proportion of military victims who were male is slightly higher than for the civilian U.S. population (78%), but that finding may be attributed to the larger proportion of males in the military. The proportion of victims who were black, however, is significantly lower than for the civilian U.S. population (49%). This finding is probably due to several factors. First, many of the black-on-black homicides in the civilian sector arise from drug-related events, and there is a relative scarcity of drug-related killings in the military. Second, many

TABLE 6–4

ACTIVE DUTY AIR FORCE HOMICIDE VICTIMS (1981–1991) BY AGE/GENDER RELATIONSHIP BETWEEN OFFENDER AND VICTIM

Offender/Victim	Number
Adult Female vs Adult Female	2
Adult Female vs Adult Male	31
Adult Male vs Adult Female	32
Adult Male vs Adult Male	123
Juvenile Male vs Adult Male	2
Unknown	5
Total	195

TABLE 6–5

ACTIVE DUTY AIR FORCE HOMICIDE VICTIMS (1981–1991) BY MILITARY GRADE

Enlisted		Officer	
Grade	Number	Grade	Number
E–1	6	O–1	3
E–2	15	O–2	2
E–3	41	O–3	8
E–4	48		
E–5	40		
E–6	21		
E–7	9		
E–8	2		
Total enlisted	182 (93%)	Total officer	13 (8%)

of those most prone to violence either do not try to enter the military in the first place or are not retained if they are successful in getting in because the military is unwilling to retain young males who enter the service but subsequently demonstrate contempt for authority or a propensity for interpersonal violence.

Although military homicide victims were killed by a variety of means, firearms led the count. A total of 106 of the victims (54%) died from gunshot wounds. This method was followed by stabbing (34), blunt trauma (18), and motor vehicles (13). These four methods represented 171 (88%) of the total. The military findings are consistent with civilian homicides in which two-thirds of the black homicide victims (66.5%) were killed with firearms and a slightly lower proportion (59.8%) of white victims were killed by firearms. After handguns, cutting and piercing instruments were the next most frequently used weapons in each group so that taken together firearms and cutting instruments were the weapons used in almost 9 out of 10 civilian homicides among blacks and 8 out of 10 homicides among whites and persons of other races.[1]

The majority of the homicides involved a lone active duty victim killed by a single offender (152 or 78% of the cases). Twenty-one (11%) of the homicides were committed by two assailants. Homicides are, therefore, primarily an interpersonal event between two individuals; this finding is consistent with the civilian experience in which among black males age 15 and above, for instance, the predominant form was a killing (by handgun) precipitated by a verbal argument.

TABLE 6–6

ACTIVE DUTY AIR FORCE HOMICIDE VICTIMS (1981–1991) BY DAY OF WEEK

Day	Number	(%)
Monday	36	(19)
Tuesday	19	(10)
Wednesday	15	(8)
Thursday	19	(10)
Friday	24	(13)
Saturday	39	(20)
Sunday	40	(20)
Unknown	3	(1)
Total	195	(100)

TABLE 6–7

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY STATUS OF THEIR VICTIMS

Victims	Number	(%)
Civilians	84*	(32)
Military Family Members	124	(48)
Other Active Duty Military Personnel	51	(20)
Total	259†	(100)

*Includes one military retiree
†243 military offenders killed a total of 259 victims

One might hypothesize that these kinds of violent episodes are more likely to occur on the weekend than during the week, and the data tend to support that assumption. As Table 6–6 indicates, Saturday and Sunday account for more homicides than would be expected by chance alone ($\chi^2 = 6.6$, $p < 0.02$).

Active Duty Offenders

Homicides are dynamic events involving a killer, a victim, and a context. Both the victim and the offender make their own unique contribution to the homicide, and the nature of the event determines whether the killing is a manslaughter, a murder, or justifiable homicide. Homicides are rarely random; perhaps the cases that come closest to a random relationship between the victim and the offender are vehicular manslaughters in which the driver at fault had no intention of killing anyone but did so during the improper or illegal operation of a motor vehicle. Most killings arise out of arguments, insults, or rivalries, and most of the time the victim is at least acquainted with his or her killer. This is equally true of military and civilian homicides.

During the same period that 195 active duty U.S. Air Force members were killed, 243 other air force members killed someone else. In 52 of these cases, one military member killed another. (49 of the cases overlap and involved air force members who killed other air force members; the other three offenders were from another branch of the armed forces.) The distribution of air force homicides by the status of the victim is reflected in Table 6–7.

Unlike the situation with air force victims, the largest proportion of offender cases did not involve murders, but they came close. As Table 6–8 reflects, the murders and manslaughters are almost evenly divided.

As in the case of active duty victims, killings by active duty members span the full range of homicidal behaviors, ranging from serial murders to vehicular homicides. The following examples illustrate some of these events:

Case Study 8

The offender, a 21-year-old single male E–4 was involved in a minor auto accident with a civilian. As their dispute escalated into a fight, the E–4 beat the civilian on the head with a baseball bat, killing him at the scene.

Case Study 9

The offender, a 31-year-old separated male E–6 was in the process of being divorced by his wife, who was leaving him for another man whom she was going to marry as soon as the divorce was final. After strangling her with her own panty hose, the E–6 wrote "hooker" on her chest with her lipstick. He then inserted the lipstick applicator up her rectum (the crime scene was "staged" to make it look as if a sex maniac had murdered her).

TABLE 6–8

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY CATEGORY OF INCIDENT

Category		Number	(%)
Justifiable Homicide		3	(1)
Manslaughter		130	(50)
Vehicular	34		
Involuntary	47		
Voluntary	49		
Murder		126	(49)
Felony Murder	19		
Arson	2		
Burglary	3		
Rape	7		
Robbery	7		
Serial Murders	7		
Other Murders	85		
Murder-Suicides	15		
Total		259	(100)

Case Study 10

The offender, a 22–year-old married female E–3 who was human immunodeficiency virus (HIV) positive, beat her 18-month-old son to death with a belt and an electrical cord (according to her, to "discipline" him). The child was found to have multiple bruises to the face, old wounds over his entire body, burns to the left knee, and a portion of his left ear was missing. The E-3 stated that the child was better off dead.

Case Study 11

A 26-year-old married black male E–4 was irritated at his 1-month-old son's crying. He shook the infant and punched him in the head, as a result of which the child died. Three years earlier, this same individual placed another infant in scalding water, inflicting such severe burns that the baby died.

The relationship between military killers and their victims is shown in Table 6–9. The proportion of homicides that involve military husbands killing their wives or children is especially noteworthy. Many of these husband versus wife homicides are consistent with the spousal homicide syndrome in which men claiming to be in love with their wives kill them for reasons related to sexual propriety (eg, the wife leaving the husband for a new partner, promiscuity, pathological jealousy, and catching the wife in an adulterous affair). Male sexual jealousy and proprietorship as motives are illustrated in the following examples:

Case Study 12

A 30-year-old married male E–7 got into a heated argument with his wife over his suspicions of her infidelity. After she admitted to having an affair, the E–7 grabbed a kitchen knife and stabbed her several times, killing her.

Case Study 13

A 24-year-old married male E–4 was sent to Saudi Arabia during Operation Desert Storm. While he was gone, his wife moved in with another man. When the E–4 returned and learned of her infidelity, he confronted her in the parking lot of a shopping center and shot her twice with a .357 pistol.

Case Study 14

A 26-year-old married male E–5 became despondent when his wife returned from a trip and told him that she

wanted a divorce. He went to his room with the intention of killing himself, and as he was looking in his dresser for his pistol, he found some love letters written by his wife to another man. He located his 9mm pistol and shot her instead.

Fully 82% of the killings by military members took place between individuals who were known to one another, with almost 60% occurring between relatives or intimates. The majority of the killers (223 or 92%) were males, and 20 (8%) were females. This difference is a finding consistent with trends in the civilian world in which killing is also concentrated among young men (primarily in their late adolescence and early adulthood).

TABLE 6–9

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY VICTIM-OFFENDER RELATIONSHIP

Victim-Offender Relationship		Number	(%)
Relatives		127	(49)
Wife vs Husband	2		
Husband vs Wife	45		
Father vs Son	31		
Father vs Stepson	8		
Father vs Daughter	20		
Father vs Stepdaughter	5		
Mother vs Daughter	6		
Mother vs Stepdaughter	1		
Mother vs Son	4		
Subject vs Other Relative	5		
Intimates		23	(9)
Ex-spouses	4		
Lovers	17		
Prostitutes	2		
Acquaintances		62	(24)
Coworkers	21		
Friend	15		
Sex-Related Triangle	9		
Caretaker vs Child	7		
Drug-Related	6		
Offender vs Med. Patient	2		
Roommate	2		
Military Member vs Stranger		44	(17)
Other		3	(1)
Total		259	(100)

In terms of race, the majority of killers (165 or 68%) were white, while 75 (or 31%) were black. The remaining 3 (1%) represented all other races. The proportion of homicides committed by blacks is double their representation in the Air Force as a whole, which is in the same direction as black homicide rates in the civilian world (where black homicide rates are approximately five times greater than white rates). Most of the black offenders in the military (58 or 75%) killed black victims; of the 19 nonblack victims killed by black offenders, 4 were their own family members, 8 were civilians, and 7 were other active duty military members.

The average age for the active duty killers was 26, which is almost identical to the average age of the military victims. As in the case of the military victims, the age is lower than the civilian average because of the age distribution of the active duty force. The average military member enlists at age 20, and because career military personnel are eligible for retirement at 20 years, the proportion of military members above age 40 diminishes rapidly.

The marital status of the military offenders is reflected in Table 6–10. The proportion of military members who killed their spouses or children mirrors the proportion of military members who are married. The question of whether the killing was related to their marital status, their military status, or neither is problematic but interesting.

Most of the homicides committed by active duty members occurred off the military reservation (209 or 81%). Of those that took place on base, 25 (or one-half the on-base total) involved the killing of a family member, and most of the rest (18) involved the killing of another military member. As in the case of the active duty victims, sex played a role in many of these deaths. Of the 259 homicides a total of

TABLE 6–10

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY MARITAL STATUS OF THE OFFENDER

Status	Number	(%)
Married*	152	(63)
Single	71	(29)
Divorced	20	(8)
Total	243	(100)

*Includes 18 separated

52 (20%) were sex-related. Most of the sex-related cases (47) involved heterosexual events, and the remainder involved homosexual events.

More of the active duty killers used a firearm than any other weapon; however, firearms were not used in a majority of the killings. Slightly less than one-third of the military killers used a firearm, which produces a noteworthy anomaly: military homicide victims are most likely to be shot, but military homicide offenders are not likely to shoot their victims. This finding suggests that military members are more likely to kill with less premeditation and more under the pressure of circumstances as they develop at the time of the homicide. Table 6–11 presents the methods used in killings by active duty members.

Most homicides by military members were committed by males whose principal targets were females and juveniles, and most of their victims were intimates or family members. In contrast, for civilian offenders in state prisons, males were the principal target (70%), and few of the victims were intimates or dependents (24%). However, it is worth noting that in populations in which the homicide rate is relatively low, the proportion of cases that occur in the family is relatively high, and this relationship holds true for the military. The age/gender relationships among the killers and their victims are reflected in Table 6–12

The homicides committed by active duty military members tended to occur on the weekends as was seen for victims of homicide ($\chi^2 = 5.4$, $p < 0.02$). As Table 6–13 indicates, Saturday was the maximum and Thursday the minimum day for homicides to occur by day of the week.

In summary, an analysis of homicides within the military yields some interesting findings. For one thing, military members are more likely to kill than to be killed. Active duty victims are most likely to be killed by someone to whom they are related or whom they know, and they are most likely to be shot. Military killers are most apt to kill family

TABLE 6–11

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY METHOD

Method	Number	(%)
Firearm	75	(29)
Blunt Trauma	55	(21)
Automobile	34	(13)
Stabbing/Cutting	31	(12)
Shaken Infant	27	(10)
Asphyxiation	16	(6)
Gross Negligence	8	(3)
Multiple Methods	4	(2)
Other	9	(3)
Total	259	(100)

TABLE 6–12

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY AGE/GENDER RELATIONS BETWEEN OFFENDER AND VICTIM*

Offender/Victim	Number
Adult Female vs Adult Female	2
Adult Female vs Adult Male	7
Adult Female vs Juvenile Female	7
Adult Female vs Juvenile Male	4
Adult Male vs Adult Female	83
Adult Male vs Adult Male	80
Adult Male vs Juvenile Female	28
Adult Male vs Juvenile Male	47
Unknown	1

*NOTE: Sixteen males killed more than one person; 15 of them killed two victims and one, a serial murderer, killed five. For purposes of this table each event is counted separately. Thus, even though 223 men killed 239 victims, the total number of "relationships" in this table totals 259.

TABLE 6–13

HOMICIDES BY ACTIVE DUTY AIR FORCE MEMBERS (1981–1991) BY DAY OF WEEK

Day	Number	(%)
Monday	35	(13)
Tuesday	42	(16)
Wednesday	28	(11)
Thursday	25	(10)
Friday	30	(12)
Saturday	53	(20)
Sunday	46	(18)
Total	259	(100)

members or other members of the military, but they are less likely to use a firearm in the commission of the crime. Murders within the military seem to conform in general to those within the civilian community except that fewer are drug-related. The status of being in the military depresses the overall likelihood of homicide. That may be due in part to personnel selection and retention procedures and may be related in part to the closely ordered nature of the military community. The bottom line, however, is inescapable: a person is safer in the military than in the civilian world, and this is especially so for black males.

Homicide Prevention

Although preventing homicides is a great deal more problematic than preventing suicides, there is still a great deal that can be done. For example, the most common homicide within the military community is the killing of infants by their parents or adult caretakers. The victim is usually under 1 year of age and is either suffocated by the mother or dies as a result of being shaken by a male caretaker (the father, stepfather, or boyfriend of the child's mother).

In some cases, parental behavior is more violent. An unfortunate case occurred overseas. Both parents were active duty, juggling demanding careers with parenting. Severe marital conflict developed, and a newborn infant became the object of the father's frustration and anger. Responding to the infant's inconsolable crying one day, the father repeatedly dropped the child on its head. The infant sustained severe injury and went into respiratory arrest, and the panicked father took the child to the local military treatment facility. He initially adamantly denied suspicions of child abuse. Subsequent investigations and prosecution uncovered the truth.

Not surprisingly, these violent deaths are significantly under-represented in homicide counts because most are never prosecuted as murders or manslaughters, and this illustrates an important point. The criminal justice system measures outcomes in terms of legal definitions rather than the larger antecedent conditions that produce them. Lethal outcomes that are the product of frustration and a lack of impulse control often slip between the cracks of the system. The people who commit these acts are typically immature, inadequate, and impulsive (indeed, this triad is a common denominator in the majority of homicides regardless of the age of the victim). Because relatively few of these deaths are intended consequences, the targeted behavior should be assaults rather than killings. If assaultive behaviors can be reduced, the number of homicides will almost certainly diminish correspondingly.

The prevention of homicide is an unrealistic goal. The force of history clearly demonstrates that violence is part of the human condition. Currently, the best option is reduction of risk factors associated with aggression.[7] The prediction of violence is fraught with error, particularly long-range assessments. Clinicians can more accurately define acute dangerousness.

The legal duty of clinicians to warn victims of violence was addressed in the landmark case *Tarasoff v. Regents of Univ of Cal*.[8] Since then, the medical community has repeatedly examined the subject. The duty to warn must be tempered by clinical judgment. The clinician must carefully weigh the risk of disclosure versus potential harm to the public. Each instance must be approached in a flexible manner to ensure that a reasonable decision is reached. One possible clinical outcome could be the absence of a mental disorder. Threatening behavior in this context could be prosecuted under military law.

From a social perspective, violence can be minimized by controlling factors that promote or facilitate the expression of violence. Substance abuse is a prime example. In the military, random urine drug screens seeking illicit drug use have conspicuously reduced consumption. Alcohol remains uncontrolled although the military policy for treatment and, where necessary, punishment are well described.[9]

Community psychiatry emphasizes prevention. The early detection and referral of emotional problems and family conflicts and identification of poor parenting skills may forestall a later crisis. In addition, command education and sensitivity to the emotional health of their subordinates are critical to prevention. Army policy, for example, mandates suicide prevention task force committees.[10] This multidisciplinary body is charged with the specific task of addressing suicide prevention at all command levels.

SUICIDE

Suicide is regarded as a major public health problem and has received considerable attention in recent years, especially in light of the growing number of suicides among young people.[11] Between

1970 and 1980, almost 300,000 people took their own lives, amounting to an estimate of one suicide every 20 minutes.[12] The military is not exempt from the problem; in fact, suicide ranks third as a leading cause of death among active duty military members (following accidents and deaths from natural causes).

There were three reasons why suicide within the military historically received relatively little attention. First, suicides were anomalies within the military community. Because the absolute number of active duty suicides is low to begin with and because their distribution across time and space further diminished their visibility, they were commonly regarded as rare events. Second, suicide was viewed as a psychiatric problem, and its management had therefore been placed outside the mainstream of command responsibility. Because mental health professionals were responsible for treating those who make suicide attempts or gestures as well as those referred for suicidal ideation, the mental health profession had "owned" the problem. Because they regard it as a psychiatric problem, the mental health community had been slow to see the relation between suicide and command responsibility. Finally, suicides had been viewed as an individual rather than collective problem; therefore, they have been seen as a problem without a solution because the death of the victim precluded any possibility of a more favorable outcome. There may even have been some general sense that someone who attempted or committed suicide could not be a great loss to the service. In short, suicides within the military have historically been viewed as an individual problem rooted in the pathology of the victim and therefore beyond the control of command authorities.

This historical attitude has changed and moderated since the end of the Vietnam conflict. In the U.S. Army, the change was driven from the top, by directive of the senior army leadership. AR 600–63[10] describes the military approach to suicide evaluation and prevention. AR 600–63 requires that every military installation assemble a suicide prevention task force committee. As a multidisciplinary body, this committee is authorized wide latitude in education and consultation. Some installations, for example, have installed a central suicide crisis telephone line. Others routinely write articles about various aspects of suicide in local military publications. Direct consultation to units is common. AR 600–63 also gives to the Chaplain Corps and the family life centers the responsibility for suicide prevention education to unit leaders and more recently, also to unit families. The chaplains usually welcome mental health assistance with this duty.

The typical small unit commander is sensitized to the emotional needs of his subordinates. At various times in their professional development, Army leaders are reminded of suicide. On some posts, command emphasis has given junior- and middle-level commanders the impression that a suicide among their subordinates could adversely affect their careers. Close liaison with military community mental health resources affords the commander the opportunity to obtain informal consultation. All units have access to these professionals. In addition, progressive substance abuse evaluation and treatment programs exist throughout the military. Substance abuse and family support programs are unique in that army regulations also define these services as command-sponsored priorities. The strains of military life as they adversely impact domestic relationships can be referred to family advocacy evaluation and treatment programs.

Despite the best efforts of these well-intentioned activities, suicide still occurs. Following any completed suicide, military regulations require a psychological autopsy. These indepth evaluations help isolate any correctable, and potentially aggravating, factors. Recommendations from the psychological autopsy may be useful in prevention.

In terms of specific numbers, since 1975, the U.S. Army has averaged 74 active duty suicides per year, and the U.S. Air Force has averaged 66 (their approximate crude rates are 12.5 and 11.5 per 1,000, respectively).[13–15] These rates compare favorably with the 1986 civilian rate of 12.8; however, the military population is not a random sample of the civilian population and, in fact, differs from it in several systematic ways. The military population is largely male, has a larger proportion of racial minorities, and has virtually no members below the age of 17 and relatively few above the age of 50.

To better understand the relation between army and civilian death rates, the army death rates were calculated for males and females and blacks and whites in 5-year age intervals for each mode of death.[16] The same calculations were done for civilians, breaking them down by race, sex, and 5–year age intervals, and the results were compared. Using a scale normalized to 100 for the case when the number of deaths observed in the Army is exactly equal to the number predicted from the civilian rates, the result is a standardized mortality ratio. This procedure is an indirect standardization and enables one to compare military deaths with civil-

ian deaths. A number over 100 means that the death rate is higher than the comparable civilian group, and a score below 100 indicates a lower death rate.

The findings were startling: Total deaths in the Army occur at one-half the rate expected from comparable civilians, with suicide occurring at about two-thirds the civilian rate. In other words, with a standardized mortality ratio of 68.8 for suicides in 1986, there were 31% fewer suicides among active duty members in the Army than would have been expected by chance alone. Comparable calculations for the Air Force for 1985 revealed a standardized mortality ratio of 58, indicating that suicide among active duty Air Force members is only slightly more than one-half the rate of a comparable civilian population.

Why are the military suicide rates lower than would be expected? The answer may lie at least in part with the fact that the military population is not randomly selected from the larger civilian population. The military population differs from the civilian population on the basis of age, race, and sex and is a filtered population consisting of those who have been physically and emotionally screened and found fit for military service. Moreover, the military population tends to be better educated and healthier and is supported by command, medical, and mental health systems that place a major emphasis on wellness. Finally, all members of the military are subject to much closer supervision and assessment than their civilian counterparts. This means that a military member who shows signs of physical or emotional dysfunction is more likely to be identified as needing care early on and is also more likely to get it in the free (and mandatory) healthcare system of the military.

Suicide Risk Factors

The information that follows is based on an analysis of 850 air force suicides that took place over a 13-year period (1979 through 1991). For purposes of this chapter, *suicide* is operationally defined as the self-inflicted death of a person, based on the victim's wish to die and an understanding of the probable consequences of his action in furtherance of that goal.[17] This definition is based on the Operational Criteria for Classification of Suicide (Exhibit 6–1). This definition, therefore, excluded certain deaths even though they resulted from the victims' own actions (such as autoerotic fatalities, eating disorders, and overly successful suicide gestures). This definition may include deaths resulting from Russian roulette if the victim fully understood and accepted the consequences of the act even though it was an act of bravado.

One of the most important relations an individual has with the military is that of rank. One's rank determines income, status, and power. In the military, a person's rank can also have a powerful

EXHIBIT 6–1

OPERATIONAL CRITERIA FOR DETERMINING SUICIDE

Self-Inflicted: There is evidence that death was self-inflicted. This may be determined by pathologic (autopsy), toxicologic, investigatory, and psychologic evidence and by statements of the decedent or witnesses.

Intent: There is evidence (explicit and/or implicit) that at the time of injury, the decedent intended to kill himself/herself or wished to die and that the decedent understood the probable consequences of his/her actions.

1. Explicit verbal or nonverbal expression of intent to kill self.
2. Implicit or indirect evidence of intent to die, such as
   - preparations for death inappropriate to or unexpected in the context of the decedent's life,
   - expression of farewell or the desire to die or acknowledgment of impending death,
   - expression of hopelessness,
   - effort to procure or learn about means of death or rehearse fatal behavior,
   - precautions to avoid rescue,
   - evidence that decedent recognized high potential lethality of means of death,
   - previous suicide attempt,
   - previous suicide threat,
   - stressful events or significant losses (actual or threatened), or
   - serious depression or mental disorder.

Reprinted from: Centers for Disease Control. Operational criteria for determining suicide. *MMWR.* 1988;37(50):773–780.

influence on his self-perception and personal as well as professional expectations. People whose age, education, or experience are not in harmony with their rank may experience more stress than their contemporaries. In addition, loss of rank or failure to progress in grade can produce considerable anxiety and stress for the individual. In the case of officers and senior noncommissioned officers, feelings of personal or professional disgrace can exceed the individual's coping mechanisms, in some cases leading to a professional crisis. The following case study illustrates this point:

Case Study 15

A 40-year-old O–4 was expected to appear in federal court to answer to charges of ordering and receiving child pornography. He was unable to keep this information from his superiors and feared public disgrace and the loss of his military status. Instead of appearing in court, he shot himself in the head with a 9mm pistol.

Table 6–14 shows the distribution of suicide victims by their military grade. In terms of their distribution, the overwhelming majority of these deaths (751 or 88%) involved enlisted members. Within the enlisted category, 68% involved people in the grade of E–3, E–4, and E–5. All but one of the remaining 98 suicides (11%) were officers; the one exception was an U.S. Air Force Academy cadet. Over one-half the officer suicides (56%) were in the grades of O–3 and O–4.

TABLE 6–14

ACTIVE DUTY AIR FORCE SUICIDES (1979–1991) BY MILITARY GRADE

Enlisted	Number	(%)	Officer	Number	(%)
E–1	33	(4)	O–1	8	(8)
E–2	39	(5)	O–2	19	(19)
E–3	156	(21)	O–3	31	(32)
E–4	180	(24)	O–4	24	(24)
E–5	178	(24)	O–5	8	(8)
E–6	93	(12)	O–6	7	(7)
E–7	47	(6)	Cadet	1	(1)
E–8	21	(3)			
E–9	4	(~0)			
Total	751	(99)	Total	98	(99)

The civilian suicide rate has historically been higher for whites than for nonwhites, with white males consistently having the highest suicide rates of any race or sex category. The ratio of white to black male suicides is 1.6 to 1, making the suicide rate for white males 67% higher than it is for black males.[12,18] Twice as many civilian white females kill themselves as do civilian black females. The same pattern is seen in the U.S. Air Force: Of the 850 suicides committed by active duty air force members from 1979 through 1991, a total of 747 (or 88%) were by whites and 85 (10%) were by blacks. The remaining 17 suicides (2%) were by all other categories.

The overall ratio of white to black suicides in the U.S. Air Force was 8.3 to 1, a figure consistent with the proportion of whites to blacks in the AirForce as a whole. Thus, race by itself does not appear to be a risk factor in the distribution of military suicides. These figures do suggest, however, that black males in the military are significantly less likely to commit suicide than black civilians. It is likely that the cultural factors that inhibit suicide among blacks within the civilian sector carry over into the military. Examination of the 86 suicides by black military members failed to disclose any unique or distinctive features related to race. Of those who left suicide notes, none indicated a racial connection to their decision; indeed, the general circumstances surrounding their deaths were indistinguishable from those of any other group.

According to the CDC,[12] almost three-fourths of all suicide deaths between 1970 and 1980 involved males. The CDC also reported that the suicide rate increased among males while decreasing among females. This pattern continued through the 1980s, with males having an overall suicide rate of 18 compared with a female rate of 5.4 or a ratio of 3.3:1. Although three times more men commit suicide than women, women attempt suicide more frequently than men. The reason for this inverse relation between gender and suicide and suicide attempts is not clear. Some have speculated that women are more likely to use drugs and poisons to attempt suicide, whereas men are more likely to use firearms,[18,19] yet there is an excellent chance that more men intend to commit suicide than women.[20] Regardless of the reasons why, suicide is more

prevalent among males than females, and this relation holds true for the military as well. During the 13-year period, 56 women took their lives, representing 7% of the active duty suicides. Because women represent approximately 12% of the active duty force, females in the air force are less likely to commit suicide than males. The overall distribution by race and sex is shown in Table 6–15.

Although there were a wide range of methods used, 85% of these suicides were accomplished by three methods: firearm (502 or 59%), hanging (122 or 14%), and auto exhaust (100 or 12%). The full distribution of air force suicides is listed in Table 6–16. In virtually all cases, the event combined a highly lethal method and a low probability of rescue.

The distribution of suicides by month for 1979 through 1991 has been remarkably consistent over time. There were an average of five suicides per month with no statistically significant differences over time among the months of the year ($F_{11,144}$=1.07, p = 0.39, ns). Although there is a widespread belief that suicides increase during the fall holidays (Thanksgiving and Christmas), no such relation was noted in the Air Force.

Similarly, for day of week for 1979 through 1991, there were no excess suicides on weekends compared with weekdays (χ^2 = .14, p > 0.7, ns), with the average number of suicides per day for Monday through Sunday being 12, 9, 8, 10, 8, 9, and 9, respectively.

TABLE 6–15

ACTIVE DUTY AIR FORCE SUICIDES (1979–1991) BY RACE AND SEX

	Number	(%)
Males		
White	702	(82)
Black	76	(9)
Other	16	(2)
Females		
White	46	(5)
Black	9	(1)
Other	1	(~0)

TABLE 6–16

ACTIVE DUTY AIR FORCE SUICIDES (1979–1991) BY METHOD

Method	Number	(%)
Firearm	503	(59)
Hanging	122	(14)
Auto Exhaust	100	(12)
Drug Overdose	44	(5)
Leap/Fall	17	(2)
Asphyxiation	12	(1)
Automobile	9	(1)
Cutting	9	(1)
Drowning	8	(1)
Unknown	1	(~0)
Other	25	(3)
Total	850	(99)

Suicide Precipitants

The term *dyad* as used in this context refers to a person's intimate associations, usually husband-wife or boyfriend-girlfriend. In some cases, understanding the exact role of dyadic relationships is complicated because of multiple simultaneous dyadic relationships (for example, unhappily married individuals who are also having problems with their girlfriends). However, the relation between dyad problems and suicide is clear and unavoidable. As Vorkorper and Petty noted, "Most suicides are dyadic. Even if the events prior to suicide are in isolation, the tension between two people continues to exist in one person's head. Frequently the tension is in the person's social relations: husband-wife, parent-child, lover-lover, employee-employer, etc."[21(p177)]

Marital status by itself offers little in the way of insight into suicide because gross figures (or percentages) do not speak to the quality of the victims' relationships. Just as a good marriage can be one of the most positive influences in a person's life, a bad marriage can create intolerable stress. Much the same can be said about other intimate relationships (ie, boyfriend-girlfriend). Table 6–17 reflects the distribution of the suicides by marital status. Some insight may be obtained from the fact that of those victims who were married at the time of their death, 32% were separated from their spouses, and fully 87% were having serious marital problems, with infidelity and abusive relationships occurring with great frequency. Of those who were

single, 62% were having serious problems in their intimate relationships, to include a majority in which the relationship had recently terminated.

Case Study 16

An 18-year-old single male E–4 with a history of financial- and job-related problems was arrested for petty larceny. His girlfriend was highly critical of his behavior and threatened to leave him. He told her that if she did, he would kill himself. After she told him she wanted to end their relationship he shot himself in the temple with a .32 revolver.

Case Study 17

A 27-year-old male E–5 was an alcohol abuser and had serious financial problems. He was unhappy with his assignment. He believed it was his destiny to commit suicide because both his father and uncle had taken their own lives. After making suicidal threats and two gestures, he was admitted for psychiatric observation. On release from the hospital, he learned that his wife had moved out and filed for divorce; he then shot himself in the head with a high-powered rifle.

Although many people assume "You have to be crazy to kill yourself," this assumption does not hold up on close examination. Very few of the victims (less than 2%) were psychotic. However, there were clear indications that at least 48% suffered from some kind of mental or emotional problem. The most frequently noted mental health problem was depression, which occurred in 40% of the cases. This is consistent with the observation that suicide and clinical depression are closely linked in civilian studies.[22] It has been reported that 90% of suicides occur in individuals with serious mental disorders (depression, schizophrenia) or substance abuse. Because the signs of depression (and many other emotional disorders) can be quickly and easily recognized, their presence offers an excellent potential opportunity for positive intervention. Moreover, treatment of depression has advanced in recent years through the development of powerful antidepressants.

TABLE 6–17

ACTIVE DUTY AIR FORCE SUICIDES (1979–1991) BY MARITAL STATUS

Category	Number	(%)
Married	462	(55)
(Separated)	(148)	
Single	298	(35)
Divorced	88	(10)
Widower*	2	—
Total	850	(100)

*Includes one individual who was a widower because he murdered his wife.

Case Study 18

A 40-year-old divorced male E–6 was chronically depressed over the consequences of his history of compulsive gambling and the financial problems that resulted. He was also an alcohol abuser. Because of his problems he was being forced to retire and became even more depressed over his uncertain future. He shot himself in the head with a .357 revolver.

Case Study 19

A 35-year-old married (but separated) female O–2 was depressed over her marital separation and the difficulty she was having with her children. She was reassigned to another hospital (she was a nurse) and did not feel close to the staff as she had at her previous assignment. She took her life by ingesting a lethal quantity of drugs.

Almost one-third of the victims were either under mental healthcare at the time of their deaths or had been recently. It is hard to interpret what this means. Not all patients want treatment and not all of them who are in treatment will cooperate with their providers. In some cases, the healthcare system may have failed to properly diagnose the severity of the problem; in other cases, it simply could not reach the victim, as shown in the following case studies:

Case Study 20

A 25-year-old single male E–3 was released from a military hospital where he had been treated for a suicide gesture. He made specific and direct comments about his intention of killing himself. After his release from the hospital, he went to a mountainous area where he shot himself in the head with a 9mm pistol.

Case Study 21

A 30-year-old married male E–6 had been suffering from chronic depression and developed a sleep disorder that persisted for several months. After telling his family that they would be better off without him, he was sent to a mental health center where he was treated for the sleep disorder and his suicidal ideation. In spite of their efforts, he shot himself in the head with a .357 revolver.

Of the U.S. Air Force suicide victims, 27% had been involved with either alcohol (17%) or drugs (10%). Approximately 6% abused both drugs and alcohol. Although substance abuse is a problem in its own right, it may also be regarded as a symptom of other, deeper problems. For some people, substance abuse may seem an effective means for coping with life's problems. For others, it is simply a means of escape. In reality, substance abuse only complicates a person's problems by preventing a more mature, effective approach to life's stresses. In addition, it complicates life by adding the negative issues associated with substance abuse to other problems. Although substance abuse is a risk factor in its own right, it should not necessarily be viewed as a cause of suicide.

Like depression, substance abuse is often visible to others. In many military cases, family, friends, and coworkers knew the individual had a problem with either alcohol or drugs; however, there were few indications that any of them sought care for the impaired individual. In other cases, they failed to do so until it was too late. In some instances, helping the victim hide a substance abuse problem represented a misguided attempt to protect the person from his or her own problems; in other cases, it represented indifference, as shown in the following case study:

Case Study 22

A 22-year-old single male E–4 was having difficulty adjusting to the military. He had a history of disciplinary problems. He complained about "not fitting in" and was a cocaine abuser. After his request for a day off was turned down, he connected a tube from the tail pipe of his car to the interior where he died of carbon monoxide poisoning.

Not surprisingly, nearly one-half of the military suicides had problems at work. In some cases, the individual brought his personal problems to work and, as a result, added his job to his other problems. In other cases, they took work problems home and added them to their dyad problems. Of those who were married, over 30% had both marital- and work-related problems. Of those who were single, over one-third had both relationship- and work-related problems. The combination of both dyad- and work-related problems is particularly stressful because it leaves the victim with virtually no safe emotional haven.

Approximately one-quarter of the military suicide victims were having financial problems at the time of their death. In some cases, the problem was the victim's spouse, whose spending was beyond the control of the victim. In other cases, the problem was the victim's own doing. Some of the victim-precipitated financial problems resulted from immaturity, whereas others were a form of acting out. Although financial problems do not appear to be a common precipitant of military suicides, when they do occur, they can be a clue to the individual's need for help. Military commanders are frequently contacted concerning subordinates' indebtedness or failure to honor financial obligations. Alert commanders often recognize this as being symptomatic of a broader pattern of ineffective coping behavior. As such, it has the potential for being another point of intervention that might collectively reduce the overall suicide rate within the military, as shown in the following case study:

Case Study 23

A 33-year-old recently divorced male E–6 was diagnosed as a hypochondriac. He was $25,000 in debt, and his security clearance was recently revoked. The loss of his clearance added to his depression, and he killed himself via automobile exhaust after leaving multiple notes.

A small number of U.S. Air Force victims (about 12%) were involved in difficulties with law enforcement agencies at the time of their death. About one-half of those were under investigation for a suspected criminal offense, and about one-half were involved in some fashion with local law enforcement agencies. Being under investigation for a suspected criminal offense, especially if the crime involves moral turpitude, is extremely stressful. This is because the legal outcomes are difficult to anticipate, and many suspects expect the worst. Legal problems almost always negatively influence one's career as conviction in court is also grounds for administrative action by the military. Thus, military members facing serious legal problems must

also worry about public disgrace and a very real threat to their military careers. For many, this is simply too much to endure, as shown in the following case studies:

Case Study 24

A 39-year-old married male O–3, formerly commander of the security police squadron, was convicted by a court martial for larceny. On the day that he was scheduled to be sentenced, he shot himself in the heart with a .38 revolver. He was found wearing his security police uniform.

Case Study 25

A 49-year-old married male O–4 was interviewed by military investigators because of an allegation that he had sodomized a 9-year-old male. The O–4 agreed to take a polygraph examination to resolve the issue, and the day before he was scheduled to take the polygraph, he shot himself in the head with a .32 pistol.

Case Study 26

A 29-year-old divorced male E–5 was under investigation for a narcotics charge and was scheduled to stand trial by court martial. While the trial was pending, he was involved in a hit-and-run accident. His blood alcohol level (0.24) was over double the legal minimum for driving while intoxicated (0.10). Following his arrest on the traffic charge, he shot himself in the head with a .38 revolver.

Suicide Communications

The actual act of killing oneself may only take a few minutes to carry out; however, suicide normally involves a great deal more than the fatal event. Impulsive suicides are rare (occurring in only 4% of the cases studied) and usually occur in a moment of great stress, as the following case studies demonstrate:

Case Study 27

A 26-year-old married male E–4 had been arguing with his pregnant wife. In a rage, he produced a pistol and threatened to kill himself. A third-party witness told him he was only joking and could not do it. The victim replied, "You don't think I can do it?" and then put the pistol to his head and pulled the trigger.

Case Study 28

A 25-year-old married male E–4 confronted his wife and her boyfriend. As they were arguing, he grabbed a 20 gauge shotgun, placed it under his chin, and pulled the trigger. He had been extremely unhappy over his marital and financial problems as well as his wife's infidelity, for which he had been receiving counseling.

Most active duty suicides are preceded by a period of personal difficulty for the victim. Although a small proportion of the suicides are impulsive (like the ones noted above), in most cases, the victim first comes on the idea of suicide as a solution to his problems and then gradually focuses on suicide as the only solution. As this process occurs, the victim comes to see life in increasingly constricted terms until his problems are seen as hopeless and suicide as the only way out. During the evolution of this process, the individual will typically drop many hints, both verbal and behavioral.

Of the 850 military suicides examined, 386 (45%) communicated their intention to commit suicide before they actually killed themselves. In some instances, these communications were clear, concise, and direct. In one case, for example, a 33-year-old E–5 who was having marital problems told his wife that if she divorced him, he would shoot himself. She told him that if he did, she would be grateful if he would at least go outside so he would not leave a mess in the house. He then went outside to a utility shed where he shot himself in the head with a .22 rifle. In many of these cases, the victims told a number of people of their plans, including coworkers and friends. In most instances, they ignored the victim and later said they "did not think that he would actually do it."

Sometimes the communication of suicidal intent was vague and only took on meaning after the victim's death. These communications often take the form of "good-bye" statements or messages. Sometimes the victim simply comments that he or she has nothing to live for. These vague comments are easy to dismiss precisely because they are so vague. Sometimes the victim is ignored because he makes suicidal comments too frequently or too explicitly, and those to whom they are made simply do not believe him. However, any suicidal statement should be taken seriously and acted on at once, as shown in the following case studies:

Case Study 29

A 35-year-old married (but separated) male E–6 had a history of work-related problems, financial difficulties, and marital strife. He had just been released from an alcohol rehabilitation program and attempted to reconcile with his wife. He repeatedly told her that if she left him, he would kill himself. She left him and he shot himself in the head with a .22 pistol.

Case Study 30

A 30-year-old married (but separated) male E–5 had a history of poor duty performance; his wife left him, filing for divorce, and he had a stormy relationship with his girlfriend whom he told he was going to kill himself. He subsequently hanged himself.

Case Study 31

A 27-year-old white male disliked his job and was having difficulty adjusting to the service. He was under treatment by mental health professionals for a previous suicide attempt. On the day of his death, he bought a high-powered rifle and left the note illustrated in Figure 6–1 in his barracks room. He was found in the area defined by the circle. He had shot himself in the middle of the forehead. Note the statement below the word *anger*: "Too much damage to go on!" This is characteristic of the kinds of hopelessness found in many suicides.

The military experience clearly indicates that suicide attempters are analytically distinct from completers. Most people who intend to kill themselves are successful in doing so, and most people who make unsuccessful attempts or gestures do not really wish to end their lives. Although there are exceptions in both categories, these generalizations have held true for the past 13 years.

Suicide attempts are themselves a form of communication and can be best understood as a plea for help. Even when the attempt or gesture is manipulative in nature, it is still diagnostic of a problem of some kind. Of the 850 people who took their lives in this study, at least 13% had made a prior suicide attempt or gesture. These unsuccessful efforts often emerge as part of a larger pattern that, if ignored, can escalate into successful self-destruction, as the following case study illustrates:

Case Study 32

A 20-year-old single E–2 had been involved in a stormy relationship with his girlfriend. He would threaten suicide, and she would talk him out of it. During the course of this relationship, he lost a part-time job because he intentionally injured himself. At about this time, a close friend killed himself over a girl, after which the E–2 became obsessed with suicide. He talked about it constantly, played Russian roulette, and made several suicide gestures. His girlfriend got tired of his behavior and broke off their relationship. After she left him, he hanged himself.

Suicidal communications after the fact usually take the form of notes left at the death scene by the victim but may also include audio or video recordings. Of the 850 military suicide victims, 366 (43%) left a note. These notes take many forms. Some are angry; others are depressed and self-condemning and many simply take the form of a last will and testament. Over one-half of those who left suicide notes also communicated their intentions prior to taking their lives. The following are examples of some of the notes:

- "Call the police. I've killed myself in the Garage" (left by a 38-year-old married male O–3 who was a Reserve Officers' Training Corps (ROTC) instructor who was depressed over his marriage and stressed in his work. He hanged himself in his garage.)
- "To my beloved wife, This will be the last time we will talk! I want you to know I loved you so much! I kept asking myself why? I could come up with no answer! Don't worry about me now, I am at peace with GOD! Finally I thought I would be afraid to die and I am. God put me on earth & I was a FAILURE! I'm sure I can do his will much better in heaven. Please comfort

Figure 6-1
19,6 x 24,9

Fig. 6–1. Suicide note on map, with the word ANGER.

my mom. She will need you more than ever! I'm so sorry! I loved you more than life itself, if only you believed in me! I will be your holy spirit forever amen! I love you! XOXXOXO" (left by a 19-year-old male E–4 who had been married for 6 months when his wife left him, returning to live with her mother. She was extremely immature and dependent on her mother, who kept telling her that her husband was no good. Two days after she left him—at her mother's urging—he hanged himself, leaving this note on the back of their wedding picture)

- "I loved her so much. I'm so sorry but this is how its gotta be. I hate life. Life's done me wrong. Please God forgive me but I'm weak. My lifes finished." (A 20-year-old male E–3 had physical problems resulting from an earlier automobile accident. He was distraught over the recent death of a close friend and told his girlfriend he was going to kill himself. Shortly thereafter, she broke up with him. He shot himself in the head with a .38 revolver)

Suicide and Malingering

Certain institutional settings, such as the military and correctional facilities, are frequently confronted with malingered behavior. The goal of this conscious deception is to avoid unpleasant duty, work, or situations. Feigning illness or injury to avoid hazardous duty such as combat is particularly important. Such unchecked conduct can rapidly deplete necessary manpower requirements. This leaves the remaining units vulnerable.

The military has always been vigilant for shirkers. Included in the Uniform Code of Military Justice is the specific crime of malingering, Article 115, which, in part, states:

> Any person subject to this Chapter who for the purpose of avoiding work, duty, or service
> 1) feigns illness, physical disablement, mental lapse, or derangement; or
> 2) intentionally inflicts self-injury; shall be punishable as a court martial may direct.[3(ppIV-68)]

The maximum punishment for malingering a self-inflicted injury in time of war includes a dishonorable discharge and confinement in prison for 10 years. Less serious malingering, such as feigning illness during peacetime, can be punished with a dishonorable discharge and confinement for 1 year.

The military crime of malingering does not discriminate mental disorder. An interesting conflict arises when suicide gestures are prosecuted. The military policy outlined in official regulations requires suicide be a command concern. Occasionally, however, repeated suicide gestures are punitively dealt with. At the unit level, frustrated commanders may respond to repeated suicide gestures with nonjudicial punishment or administrative separation from the service.

In only the rarest cases does a suicide attempt result in prosecution by court martial. This was the case in *U.S. v. Johnson*.[23] Johnson's legal case was complicated by the uncontroverted use of heroin. After his arrest for possession of the narcotic, Johnson fashioned a crude noose from an electrical cord and attempted to hang himself in the military police building. Johnson was hospitalized for a week following this attempt. Following discharge, Johnson purchased a quantity of heroin and injected a large amount. This near-fatal overdose represented a second serious suicide attempt. The gravity of this act was underscored by the accidental discovery of Johnson in a near-death condition. Prosecution and conviction were upheld by the U.S. Court of Military Appeal, the highest military court.

Assisted Suicide

In some rare cases, a suicide involves the participation of another person. These deaths raise difficult ethical, moral, and legal concerns. The military is not immune to such dilemmas.

In *U.S. v. Verraso*,[24] the accused soldier Verraso assisted in the suicide death of another soldier, Tamary Meza-Luna. Court records indicate that Verraso placed "the loop [of rope] around her [Meza-Luna's] neck leaving about three inches of slack between the rope and her neck." Verraso then left the area only to find out the next morning that Meza-Luna had indeed died. The relationship between these two people was complicated and had involved a prior joint suicide gesture. Verraso was convicted and received an 8-year prison term for her complicity.

Suicide Prevention

Some proportion (possibly as much as one-half) of active duty suicides may be preventable. Some individuals at high risk for suicide may exhibit signs that should alert coworkers. Military members work in units where their behavior is observ-

able and where support is available. Because of this, the military is theoretically an ideal environment for suicide prevention. The problem in applying these resources is twofold: (1) getting first-echelon supervisors and coworkers to *recognize* the problem in the first place, and (2) getting them to *act* on it. With respect to the former, there are a number of hurdles to overcome. The overwhelming majority of active duty suicides involve people who are quite ordinary in most respects; however, their perceived problems are greater than their coping skills. As a result, they are likely to be depressed, and the symptoms of depression can serve as tripwires that indicate a need for remedial action. For example, many of them become distant and self-isolating. Their coworkers are likely to misread these signals and simply write them off as a jerks and reciprocate by ignoring them. Because they are essentially "normal" when they talk about suicide, their coworkers disregard them and assume they are either "kidding" or exaggerating how they feel.

Even if coworkers or immediate supervisors suspect a person might be at risk, many do not know what to do. Some of them ask the potential victim to promise not to do anything stupid; others ignore them because they feel uncomfortable about dealing with another person's personal problems. Some are unwilling to refer them to the mental health professionals because they think doing so will have a negative impact on their careers. Some simply do not know what to do and put off taking action until they are forced to do something.

This is ironic because military members are under almost constant surveillance by subordinates, peers, and supervisors. Any change in personality or overt behavior ought to be readily apparent and, when correctly interpreted as being symptomatic of a problem, should trigger an organizational response. Moreover, immediate coworkers are often aware of one another's problems, especially if those problems are serious. Thus, a coworker who knows a colleague is separated and in the process of getting a divorce, who is depressed at the prospect of losing custody of his children, and who has financial and substance abuse problems, should have good reason to suspect the victim is on seriously shaky grounds. When this is compounded by the victim making "good-bye" statements or even by talking about suicide, his colleagues need to recognize that the victim is in a serious emotional crisis and that suicide is a possible outcome. The following case studies illustrate this point:

Case Study 33

A 38-year-old E–5 had a history of marital problems. His wife told him she wanted a divorce. He had financial problems, and his performance at work was slipping. Shortly after going to mental healthcare for "stress," he shot himself in the head with a .22 rifle.

Case Study 34

A 40-year-old E–6 was separated from his wife. He had serious financial problems and had been arrested for driving while intoxicated. He complained about being overstressed at work and told several coworkers that he was thinking about killing himself. The coworkers told his first sergeant, and while the first sergeant was thinking about directing him to mental health, the E–6 shot himself in the chest with a shotgun.

Case Study 35

A 21-year-old E–2 was involved in a stressful relationship that was terminated by his girlfriend. He told her that if she left him, he would kill himself. She contacted his NCOIC (noncommissioned officer in charge), who took no action. The E–2 shot himself in the chest with a revolver.

Case Study 36

A 23–year-old E–4 was separated from his wife and had serious financial problems. He told several coworkers that he didn't think he could get "out of the hole he dug for himself." Three days before he was due to appear in court on a bad check charge, he shot himself in the right temple with a pistol.

All of the cases cited above (and none of them are unusual) share several common features. First, the victims were experiencing serious problems in their intimate relationships; second, each had colleagues who were well aware of the victim's problem; and finally, helping resources exist that could have addressed all of these problems but were not used.

Failure to prevent suicides generally occurs for one or more of the following reasons. First, the victim concealed the potential for suicide because of his problems, and coworkers were not aware of that possible outcome. In this connection, it is important to remember that a certain proportion of people at risk are going to kill themselves, and there is probably nothing that can be done to stop them. Second, some suicides are leadership failures. In this category, the signs and symptoms although clear were ignored. Most of the time when this happens, it is because others are afraid to "mess

with another person's personal affairs" or because they do not know what to do or who to turn to for help. Finally, some suicides are mental health failures. A substantial minority of individuals at risk go to a mental health professional (either by referral or at their own initiative) and, for whatever reason, subsequently kill themselves.

The second problem in preventing suicides in the military involves how the system reacts to potential suicides when they are identified. The suicide "problem" is widely regarded as "belonging" to mental health. When people are identified as being at risk, they are likely to be sent to a mental health professional for evaluation and treatment. A good many mental health professionals believe that suicide is a psychiatric problem, and their evaluation protocols typically involve clinical interviews that look for psychiatric problems. If the person who has been referred is depressed but does not suffer from a psychosis or debilitating character or personality disorder, he may be able to talk his way out of treatment.

This is compounded by the fact that primary care providers in the military are typically young and at the entry phase of their careers. In a nutshell, many of them are easily misled by those whom they evaluate. If a person is sent to a mental health professional for suicidal ideation, all he needs to do is tell the provider he was feeling blue but now realizes the error in his thinking and is embarrassed at the stir his comments have set into motion. If the counselee shows the appropriate deference and talks a good game, he will be quickly released with the diagnosis of acute adjustment reaction and told to call back if he thinks doing so is necessary.

How then does one know if there is a suicide problem or if the number of suicides at a given military facility is "within normal limits?" It is the judgment of the first author that three suicides within any 12–month period constitutes a cluster and indicates the existence of a problem. When viewed as a tripwire, this figure can be used to initiate an examination of the context in which the suicides occurred to see if the problem is either a leadership or mental health professional failure.

Military communities interested in suicide prevention look for ways to keep people at risk from killing themselves. Suicide prevention programs may offer hot lines so people contemplating suicide can call someone who will listen to them or by putting out fact sheets or information bulletins on suicide. Although these approaches have value, they may not be the most effective way to prevent suicides. Based on the theme of failure seen in suicide notes, it might make more sense to offer programs to help people deal with failed relationships and financial, substance-abuse, and work-related problems. These people do not kill themselves because they want to die; they kill themselves because they cannot cope with their problems, and suicide is a vehicle for making the problems go away. Programs that deal with those kinds of problems may have the indirect consequence of reducing suicides.

CONCLUSION

Violent deaths are neither random nor mysterious events. They occur within specific contexts and can be understood in light of the overall events of which they are a part. They are difficult to prevent because they often represent circumstances largely created by people who then react badly to those circumstances. The prevention of violent deaths requires the identification of those at risk and intervention in ways that facilitate positive outcomes. The people in the best position to identify those at risk are the individual's coworkers and immediate supervisors; however, many of them do not know how to recognize risk factors or what to do even if they do recognize them. The military is in an ideal position to deal with this issue through its professional military education. By training supervisors to recognize the symptoms of those at risk and by encouraging them to make the appropriate referrals, it should be possible to offer the kinds of intervention that are likely to make the biggest difference.

In conclusion, homicide and suicide in the military have been less frequent than in civilian life. The circumstances of military and civilian deaths are similar with the preponderance of interpersonal conflict and the notable exception of the lack of drug-related murders within the military. We find no evidence that the lethal violence that is the mission of the military is reflected in the lives and deaths of active duty military personnel.

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