Suicide and Dominant Masculinity Norms Among Current and Former United States Military Servicemen

Shaun Michael Burns  
Ryerson University

James R. Mahalik  
Boston College

Recent statistics suggest current and former United States military personnel are at a greater risk for suicide than ever before. Indeed, approximately 300 active-duty servicemen died by suicide in 2009, a population-adjusted death rate exceeding that of civilians (U.S. Department of Defense, 2010). Despite a growing body of literature highlighting the adverse consequences of men’s adherence to traditional masculine norms on their physical and emotional health, little attention has been paid to the contributions of compliance with these norms on current and former male military personnel’s risk for suicide. The present manuscript highlights the need for greater consideration of servicemen’s adherence to norms of masculinity to better understand their suicide risk. To organize this presentation, the authors discuss how current and former servicemen’s adherence to social and military injunctions for masculine behavior may contribute to an unwillingness to utilize mental health services that, in turn, exacerbates their mental health and may contribute to their risk for suicide. The authors also provide specific recommendations for gender-sensitive treatment interventions and future research.

Keywords: gender, depression, men, military, suicide

Though the historical rate of suicide among United States military personnel is low compared to that of civilians (Stander, Hilton, Kennedy, & Robbins, 2004), recent statistics suggest current and former servicemen and women are at a higher risk than ever before (Kuehn, 2009) with current rates exceeding that of comparable civilian groups for the first time in recorded history (National Institute of Mental Health, 2010a). Indeed, suicide is one of the leading causes of death among military personnel (Kang & Bullman, 2009). In 2009, for example, at least 160 active-duty Army service personnel died by way of suicide, a rate of one suicide every 36 hours (United States Department of Defense, 2010). This same year, 52 active-duty Marines died through self-inflicted wounds, the second leading cause of death after combat-related incidents (U.S. Marines Corps, 2010).

As in the general population (National Institute of Mental Health, 2010b), analyses of military suicides suggest that men are at an increased risk relative to their female counterparts. Scoville and associates (2007), for instance, found that men serving in the Armed Forces between 1980 and 2004 were 3.5 times more likely to complete suicide than women. In another investigation, Stander and colleagues (2004) found that Naval men were six times more likely to suicide. Despite these statistics, however, few explanations are offered for current and former servicemen’s increased risk.

While numerous factors likely contribute to the high rate of suicide among current and former men in the military, one specific factor that may affect their risk is the gender norms (i.e., ways of thinking, feeling, and acting based on socially prescribed norms of masculinity) they enact (Houle, Mishara, & Chagnon, 2008). Specifically, pressures experienced by many servicemen to conform to a narrow range of normative masculine behaviors (e.g., being independent and unemotional) may contribute to their risk by leading them to avoid sources of support and dissuading them from utilizing mental health services (Addis & Mahalik, 2003).

In this article, we illustrate how specific dominant cultural and military-specific injunctions for masculine behavior may affect current and former servicemen’s mental health and willingness to rely on available supports, which, in turn, may contribute to their risk for suicide. In doing so, we recognize that some masculine norms may be important for some servicemen, but not for others. Consistent with interpersonal theory (Kiesler, 1983), the authors also believe that gender norms may be adaptive for men if flexibly enacted. However, the purpose of discussing each norm is to help health care professionals better understand how adherence to masculine norms may affect current and former servicemen in ways that dissipate them from seeking help for, and exploring, mental health problems. This discussion begins by describing the masculine socialization process and how it may be relevant to understanding current and former servicemen’s mental health. Next, the authors describe how servicemen’s enactment of specific norms of masculinity may contribute to their risk for suicide. To translate these findings into descriptions that health care professionals...
might better recognize, the authors provide composite, fictitious case examples derived from the first author’s experience working with male military personnel in the Veteran’s Administration. In concluding, the authors suggest a framework of gender-sensitive treatment strategies and directions for future research.

Gender Socialization and Masculine Scripts

The process of gender socialization is described as one in which cultural forces (e.g., peers, parents, media) influence males and females to adopt specific gender ideals (Kilmartin, 2007). These ideals guide masculine and feminine identity development by dictating how boys and girls are socialized, what tasks children are taught, and what life roles are acceptable for men and women (Best & Williams, 2001). By way of these processes, boys learn powerful and enduring ideals about their social roles and how they should think, act, and feel in those roles (Mintz & O’Neil, 1990). With time, these ideals become scripts of acceptable ways for boys and men to think, feel, and behave (Mahalik, Good, & Englar-Carlson, 2003).

According to Brooks (2001), military training may enhance compliance with these scripts. Many men enter the military during the transition from adolescence to adulthood, when they are likely to possess a poorly defined understanding of adult roles (Arkin & Dobrofsky, 1978). During military training men are socialized to conform to masculine norms such as self-reliance and emotional stoicism, and punished (e.g., verbally ridiculed) for deviating from these norms (Rosen, Weber, & Martin, 2000). Adherence to masculine norms is emphasized to avoid the demonstration of vulnerability, aid in meeting the physical challenges of military training, and to promote a unified fighting force (Arkin & Dobrofsky, 1978). Competent servicemen are, therefore, thought to embody these attributes, while servicemen that deviate from these norms are believed to jeopardize their safety and that of their fellow servicemen (Brooks, 2001).

Though few investigations examine conformity to masculine norms among military personnel, what research does exist suggests many such men strongly adhere to these norms. Jakupcak and colleagues (2006), for instance, found high levels of emotional restriction and fear of emotion among male veterans. Similarly, research by Kurius and Lucart (2000) demonstrated that active-duty male personnel were more likely than civilian men to embrace antifeminist beliefs and to value masculine toughness and dominance. Servicemen’s adherence to these norms, argues Brooks (2001), may facilitate a fixed, hyper-masculine identity that guides their gender-related attitudes, beliefs, and behaviors through the course of their lives.

Consequences of Adherence to Traditional Masculine Norms

A growing body of literature highlights the adverse consequences of adherence to masculine norms on men’s health and health behaviors. For example, men who adhere to traditional norms engage in more risky cardiace-related behaviors (Mahalik, Burns, & Szydlek, 2007) and problematic alcohol and tobacco use (Mahalik, Lagan, & Morrison, 2006), and are less likely to utilize professional assistance for acute life stressors (Vessey & Howard, 1993) and depression (Carpenter & Addis, 2001). Similarly, men who conform to traditional notions of masculinity are less likely to consult medical and mental health care providers (Addis & Mahalik, 2003) and more likely to engage in violence and aggression (Locke & Mahalik, 2005).

Thus, research confirms that masculine gender norms are an important correlate of the health and health-related behaviors of men. In the next section, specific scripts are highlighted that may be particularly relevant to understanding current and former servicemen’s mental health and willingness to utilize mental health services, and, in turn, contribute to their risk for suicide.

Self-Reliance and Servicemen’s Risk for Suicide

Self-reliance is a traditional masculine script encouraging men to “do it yourself,” and “stand on your own two feet.” In the military, this script has particular resonance as rugged individualism and physical and emotional toughness are highly valued personal characteristics (United States Army, 2010). From early in the training experience, recruits are taught to function as a self-reliant part of a team through a series of reinforcements (e.g., medals for valor) and harsh punishments (e.g., physical intimidation for failure, demotion; Quick, Joplin, Nelsen, & Mangelsdorff, 1996). As a consequence, men in the military frequently adopt what is described as a “masculine warrior” identity marked by feelings of invulnerability and courage, disavowal of weakness and discomfort, and extreme independence (Dunivin, 1994).

As a result of pressures to enact this script, men in the military are often unwilling to ask others for psychological help (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Military servicemen may be reluctant to seek help as a result of strong institutional pressures to independently manage problems that may impair readiness or reveal individual vulnerabilities (United States Army, 2010). For servicemen who do utilize psychotherapeutic services, feelings of helplessness, powerlessness, and failure are not uncommon (Pietrzak et al., 2009).

Because of the high value placed on self-reliance during military training (Brooks, 2001) and the strong stigma of mental disorders within the Armed Forces (Pietrzak et al., 2009), self-reliance may be particularly relevant for current and former servicemen living with mental health problems or suicidal thoughts. Indeed, to combat these feelings servicemen often go to great lengths to manage their symptoms independently (United States Army, 2010). Consider, for example, Roy:

Roy, a 26-year-old 1st Lieutenant in the Air Force, experiences depressive symptoms and passive suicidal ideation. As a result, Roy has difficulties performing work-related tasks and has been reprimanded by his superiors for his poor performance and perceived indifference to his work. Given his concerns about the impact of his difficulties on his family, Roy has begun contemplating ending his life. Upon noticing his withdrawal during family dinners, Roy’s spouse encourages him to seek support at the Air Force base. After reluctantly agreeing to attend an appointment with a military physician, Roy appears distressed about the impact these “feelings” have on his work. To aid Roy in combating his symptoms, his physician offers him the phone number of a civilian social worker and the address of a support group for men. Roy, however, appears uninterested in these sources of support, stating, “This is just something I have to learn to live with, and I have to do that myself. Asking someone to fix my problems or crying to someone isn’t going to change a thing, and will probably just make me feel like a sissy.”
Like Roy, many current and former servicemen are reluctant to rely on others to cope with their difficulties. Indeed, research by Duggal and colleagues (2010) demonstrated that male veterans are significantly less likely than females to use Department of Veterans Affairs mental health services. Similarly, in a recent report by the United States Army (2010) several active-duty male participants voiced a preference to manage emotional difficulties independently for fear that disclosing such difficulties may negatively affect their opportunities for promotion.

Although being self-reliant may enhance feelings of self-worth for men like Roy (Solomon, Greenberg, & Pyszczynski, 1991), servicemen who define their masculine identities by handling their problems on their own may experience a variety of adverse outcomes. For instance, prior research suggests that male combat veterans who adhere to norms for self-reliance are likely to delay treatment-seeking longer for panic-related chest pain and, as a consequence, experience prolonged symptom duration (Alcaras & Roper, 2006). Similarly, servicemen who cope independently with mental ailments are more likely to view suicide as a feasible means of coping with their difficulties (Brenner et al., 2008). According to Greene-Shortridge, Britt, and Castro (2007), men who manage their symptoms through self-reliance may lack sufficient social and emotional resources to cope with their difficulties.

Emotional Control and Servicemen's Risk for Suicide

Emotional control is a masculine script suggesting that “boys don’t cry” and that men should not reveal feelings. As a result of these injunctions, strong emotions for many men are a symptom of weakness and avoided (Cochran & Rabinowitz, 2000). Mahalik and colleagues (2003) suggested this tendency may stem from social expectations that men be tough and stoic. From an early age, boys learn not to cry when in pain and that emotional expression is effeminate (Levant, 1998). As a result, men are often unwilling to voice feelings that elicit support (Addis & Mahalik, 2003). Discussing symptoms of depression, for example, may be a source of shame for men who adhere to this script (Shepard, 2002). Consequently, men bear much of their emotional distress in silence (Kornblith, Herr, Ofman, Scher, & Holland, 1994).

Given the high prevalence of psychological disorders among current and former servicemen, adherence to scripts for emotional control, like self-reliance, may be important to understanding their risk for suicide. Research indicates that 14% to 17% of active-duty military personnel returning from combat operations in Iraq and Afghanistan meet diagnostic criteria for Post-Traumatic Stress Disorder (Kang & Bullman, 2009), while an estimated 31% of Vietnam veterans have a lifetime history of the disorder (Kalika et al., 1990). Approximately 20% of veterans serving in the military since 2001 meet criteria for a Major Depressive Disorder, six percent a substance abuse or dependence disorder, and 10% another Axis I condition (Dedert, 2009). Further, roughly one in 20 active-duty military personnel stationed in Iraq during Operation Iraqi Freedom acknowledged frequent suicidal ideation (McNulty, 2005).

For many servicemen, reactions to such difficulties are seldom voiced (Mahalik et al., 2003). Consider Kenneth:

Kenneth is a 64 year-old retired veteran of the Air Force. In the weeks following the United States’ initiation of combat operations in the Middle East, Kenneth spent a considerable amount of time watching TV shows about this conflict as well as various documentaries about the United States’ involvement in the Belgian Congo during his service. Although Kenneth denies that combat in the Middle East has caused him to experience feelings of sadness or negative memories related to his own involvement in combat, his wife notes he spends an increasing amount of time alone and that “he no longer plays cards on Thursdays with his friends.” Similarly, she notes that Kenneth spends most evenings reading firearm reviews and fears this may reflect underlying emotional problems that he refuses to voice. When his wife asks Kenneth to talk about his feelings, he appears annoyed and yells, “Quit prying! Talking about this is only going to make it worse, and it’s no big deal anyway.”

Like Kenneth, many servicemen are unwilling to share their emotional difficulties. Indeed, in research by Price and associates (2005) a significant portion of veterans treated for Post-Traumatic Stress Disorder expressed reluctance to discuss their emotions for fear of losing affective control. In a sample of active-duty combat veterans returning from Afghanistan and Iraq, Hoge and colleagues (2004) found that 38% of respondents with a psychological problem did not trust mental health professionals, while 41% were reluctant to utilize mental health services for fear of being embarrassed. In an investigation by Brenner et al. (2008), veterans of the Armed Forces reported coping with difficult emotions through alcohol and illicit drug consumption, emotional detachment, and physical violence.

Although few studies explore the impact of servicemen’s adherence to scripts for emotional control on their psychological adjustment, what evidence does exist suggests that emotionally controlled men evince poorer mental health. In a study of the coping behaviors of a predominantly male sample of Vietnam veterans, for instance, men who coped with combat experiences through emotional blunting evinced lower life satisfaction and poorer adaptation (Suvak, Vogt, Savarese, King, & King, 2002). In a related investigation, Price and associates (2005) found that former servicemen who avoided emotional expression demonstrated poor adjustment to trauma.

These findings, although limited in number, underscore the importance of men’s emotional control as a correlate of their mental health. According to Addis and Mahalik (2003), men who employ emotional control to manage their emotions may fail to voice vulnerabilities that elicit support. This unwillingness may, in turn, leave men alone to cope with their emotions and contribute to their risk for suicide (Houle et al., 2008).

Gender-Specific Treatment Recommendations

From the preceding discussion, it is evident that treatments that fail to consider current and former servicemen’s gender scripts may be less effective in helping them adjust to emotional difficulties (Addis & Mahalik, 2003). Even with this understanding, however, professionals who treat servicemen may wonder how to incorporate masculine gender scripts into their practices. To this end, the following strategies are recommended.

Identify Salient Masculine Scripts for Servicemen

First, as servicemen are likely to differ in the way that they define masculinity, clinicians should identify which scripts are
salient for their patients (Mahalik et al., 2003). For one man, being emotionally controlled may be most central to his masculinity, whereas for another being self-reliant may be most critical. Although these scripts are likely related to each other, we suggest that professionals identify the specific scripts their patients adhere to rather than talk about masculinity in a global way. Consider, for example, Roger:

Roger is a 23 year-old active-duty Marine Sergeant who has experienced difficulties sleeping, poor concentration, and passive suicidal ideation since his involvement in a near-fatal roadside bombing in Iraq. At support group meetings on base, Roger talks about how much he appreciates the support offered by the group as he does not feel so alone with problems. He also reports feeling “depressed,” however, because of his perceived inability to manage his problems on his own. In the group he states, “I didn’t realize how much I valued being independent until I finally realized this problem wasn’t going away and I had to ask my Chaplain for help. That was the hardest part, but, I am determined to get back to the way I was before.”

Like Roger, some servicemen may be reluctant to rely on others to combat emotional difficulties but feel comfortable discussing their mental health in a group. Other men may feel uncomfortable discussing their emotional reactions but view relying on, and asking for help from, mental health professionals as a critical part of recovery. Health professionals’ observations of their patients’ behaviors and queries about servicemen’s willingness to rely on others and discuss difficulties may provide valuable insight into which masculine scripts are most important to the men they treat. This insight may, in turn, aid in identifying scripts that exacerbate emotional problems.

Identify Positive Aspects of Servicemen’s Adherence to Masculine Scripts

Clinicians should also explore positive aspects of servicemen’s adherence to masculine scripts (Mahalik et al., 2003). Consider Ronald:

Following his diagnosis with a Major Depressive Disorder by his physician and a near fatal overdose in 2010, Ronald, a retired Korean War veteran, sought psychiatric treatment at a VA hospital. Although he continues to experience decreased energy and intermittent thoughts of death, Ronald reports a great deal of satisfaction with his life. In a visit to his psychiatrist Ronald says he is “coping fine on [his] own” and feels good that he is in control. He notes that although feeling more energetic and reducing his thoughts of death represent important goals for him, he does not let these difficulties bother him because “getting upset doesn’t change a thing,” and he feels there are many good things he can achieve even if doesn’t always feel his best.

For some servicemen, self-reliance may prove helpful in coping with emotional difficulties as enactment of this script may allow men to retain a sense of mastery over their difficulties, act decisively, or be assertive (Sharpe, Heppner, & Dixon, 1995). Self-reliant servicemen may, for example, independently seek mental health treatment as a determined act to overcome depressive symptoms. Similarly, men may benefit from efforts to limit emotionality as the expression of strong emotions may prove overwhelming. Emphasizing and reinforcing these strengths not only demonstrates respect for servicemen’s efforts (Grüninger, 1995), but may also reduce embarrassment, encourage disclosure, and improve patient-clinician communication (Rappaport, 1984).

Help Servicemen Identify the Costs of Adherence to Masculine Norms

After identifying the norms their patients adhere to and the benefits these scripts may provide, clinicians should help current and former servicemen examine the costs of these norms in relation to their presenting concerns (Mahalik et al., 2003). Consider, for example, Dennis:

Dennis, a 34 year-old, married, former Coast Guard member, experiences intermittent thoughts of “stepping in front of a bus.” Although he reluctantly accompanies his wife to marital therapy, Dennis refuses to discuss his psychological symptoms or their impact on the relationship, claiming that he “would rather be dead than burden her” with his emotions. In the course of therapy, it becomes apparent that Dennis is greatly distressed by his suicidal thoughts and that much of the discord in the relationship centers on this issue. When driving home after sessions, Dennis complains therapy is a waste of time, that the couple can resolve their difficulties on their own, and that he can independently manage his problems.

When treating self-reliant men like Dennis, therapists may encourage them to consider the way their autonomous coping limits the quality and type of help they receive. For example, a client might be urged to explore the way his self-reliance contributes to his feeling of not being understood and how these feelings foster his sense of loneliness. Similarly, emotionally controlled servicemen may be prompted to examine how their emotional restriction contributes to feelings of disconnection or isolation in family and social relationships. According to a recent report by the United States Army (2010), encouraging help-seeking among military personnel by legitimizing emotional disclosure and reliance on available supports represents an important avenue for reducing military suicides.

Aid Servicemen in Examining and Reconstructing Maladaptive Masculine Scripts

Finally, confronting emotional difficulties may afford servicemen an opportunity to examine and reconstruct their masculine identities (Mahalik et al., 2003). For many servicemen, successful adaptation to mental illness may require such reconstruction. To aid men in this process, clinicians might encourage current and former servicemen they treat to adopt greater flexibility in their gender scripts (Mahalik et al., 2003). For instance, clinicians can encourage men to reconstruct identities with greater flexibility in self-reliance. To illustrate, consider Eric:

Eric, an 84-year-old former Marine, has experienced frequent suicidal thoughts since relocating to a retirement community in 2007. Although he enjoys socializing in the community, he seldom does so for fear that others will “see that [he is] not doing well.” As a consequence, Eric spends the majority of his time alone, breaking his isolation only for biweekly sessions with the staff psychologist. In these sessions, Eric states that although he often feels isolated and would like to talk to others in the community, he prefers to be alone rather than “complaining or looking like a weakling who can’t handle [his] own problems because that’s just not what Marines do.” To aid Eric in identifying the costs of his self-reliance, his psychologist
acknowledges that self-reliance is a method of coping often employed by men but suggests that it also may be contributing to his feelings of isolation. As a way of reconstructing his self-reliance, Eric agrees to talk more directly to his psychologist and medical care providers about managing his symptoms. Ironically, Eric reports that “relying on others” help at this point may be [his] best bet” to achieve greater self-reliance in the future.

Other strategies to help servicemen like Eric in reconstructing their self-reliance may involve aiding them in identifying positive sources of support such as spouses, significant others, or coworkers (Courtenay, 2001) and by highlighting the potential benefits of reliance on these supports. Men like Eric may also develop greater flexibility in their self-reliance through participation in group psychotherapy (Robertson, 2001). Given the camaraderie experienced by many servicemen during their military training (Brooks, 2001), the group atmosphere may prove especially beneficial for modeling the benefits of relying on others for Eric by providing him a context for expressing concerns, forming relationships, and sharing experiences with other men (Rabinowitz, 2001).

Similarly, if the costs of emotional control appear to outweigh the benefits for servicemen, clinicians should assist them in adopting greater flexibility in this script. Consider Andres:

Andres is a 35-year-old National Guardsman who is currently prescribed a Selective-Serotonin Reuptake Inhibitor by his Nurse Practitioner to combat symptoms of depression. Despite beginning psychopharmacological treatment, however, Andres continues to experience difficulties sleeping, decreased energy, and poor concentration. Although his wife encourages him to talk about his problems, Andres minimizes his concerns for fear of burdening her “with little stuff that doesn’t matter.” When visiting his Nurse Practitioner, Andres seldom asks questions because he does not want to “appear hysterical” and believes “doctors can’t change anything anyway.” On noting Andres’s tendency to avoid emotional disclosure, his Nurse Practitioner encourages him to reconstruct this script by stressing that restriction of emotions can have adverse effects on his health and that “there are no medals for holding back feelings.” With time, Andres agrees to share more of his feelings with a licensed clinical social worker “one of [his] buddies found helpful.”

Additional strategies for helping current and former servicemen like Andres in reconstructing this script may include reducing shame and embarrassment about expressing emotions by asserting that sharing feelings is an act of determination or courage rather than a vulnerability (Courtenay, 2001). Similarly, his Nurse Practitioner can stress that depression is difficult to adjust to and that many men who are treated for the ailment experience periods of distress (McCarthy & Holliday, 2004). These actions are likely to legitimize emotionality and to aid men like Andres in developing greater comfort with, and flexibility in, expressing vulnerabilities (Courtenay, 2001).

**Conclusion**

Though few prior investigations examine conformity to masculine norms among military personnel, servicemen’s adherence to these norms and their risk for suicide represent an important context for the study of gender and mental health. Indeed, while a variety of recent research has identified important correlates of servicemen’s risk for suicide, we argue that any framework for understanding this risk is incomplete without consideration of men’s gender identities and the social and institutional pressures they experience to retain these identities. Research suggests a substantial portion of current and former military personnel live with a psychological ailment (e.g., Kang & Bullman, 2009) and frequent suicidal ideation (McNulty, 2005). For many servicemen, combating these difficulties through reliance on available supports may prove incompatible with socially constructed masculine ideals which are reinforced during military training (Brooks, 2001). Adherence to these ideals, however, may contribute to servicemen’s risk for suicide by dissuading them from utilizing mental health services. Although research is needed to test our suggestions, the authors propose that servicemen’s adherence to scripts for self-reliance and emotional control reflects an important and heretofore neglected factor that may lead to better understanding of their risk for suicide.

Future directions for research may include assessing the interactive relationship between masculine gender norms and commonly identified correlates of suicide among servicemen. For instance, as a variety of investigations suggest that servicemen with chronic or life-threatening illnesses are at a greater risk for suicide (e.g., Kaplan, Huguet, McFarland, & Newsom, 2007), continued research might explore the interactive relationship between health and masculine norms in predicting this risk. Similarly, as noted, research suggests that men who adhere to traditional norms are significantly more likely to abuse substances than men with more flexible gender orientations (Mahalik et al., 2006). As recent statistics suggest suicide among current and former military servicemen is often associated with substance abuse (United States Army, 2010), future research might explore the impact of gender-specific substance abuse interventions on servicemen’s risk for self-harm. Further, though we argue that gender norms are important in understanding suicidal behavior among current and former military men alike, existing mental health interventions for active-duty servicemen are frequently short in duration, solution-focused (Tanielian & Jaycox, 2008), and unlikely to incorporate gender-related considerations. As research suggests these servicemen frequently embrace traditional masculine ideals (e.g., Rosen et al., 2000), we recommend future research explore the utility of gender norms in reducing suicide risk among active-duty personnel. Similarly, as research suggests the prevalence of men’s suicide and conceptions of masculinity change through time (Hunt, Sweeting, Keoghlan, & Platt, 2006), we encourage future investigations to examine rates of vulnerability to suicide among different generations of male servicemen. Moreover, as recent studies (e.g., Rochlen, Land, & Wong, 2004) suggest that men may favor supportive resources that allow them to preserve their anonymity, future investigations might explore the effects of alternative supports such as online listservs or chat rooms in reducing current and former servicemen’s risk. Finally, although we offer a number of potentially useful therapeutic strategies in the present article, we recognize the need for research efforts to develop empirically supported guidelines for interventions aimed at improving servicemen’s adjustment and decreasing their risk for suicide.

**References**


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