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Research Article

Suicidal Ideation in Combat Veterans: A Literature Review

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Abstract

Suicide among combat veterans represents a complex and urgent public health concern, with rates of suicidal ideation and behavior significantly exceeding those observed in the general population. This elevated risk is closely associated with co-occurring mental health conditions, including posttraumatic stress disorder (PTSD), major depressive disorder, substance use disorders, and moral injury. Additionally, cultural and systemic barriers—such as stigma, reduced help-seeking behaviors, and challenges in accessing care—further complicate prevention and intervention efforts within this population. This manuscript provides a focused review of peer-reviewed literature published between 2020 and 2025, examining the intersection of mental health symptomatology and suicide risk among combat veterans and first responders. Particular attention is given to identifying evidence-based crisis intervention strategies, including trauma-informed approaches and rapid response models tailored to high-risk populations. The review also explores the role of peer support interventions in engaging individuals who may be reluctant to access traditional mental health services, highlighting their effectiveness in fostering trust and promoting early intervention. In addition, the manuscript addresses the importance of integrating spiritual and cultural considerations into suicide prevention frameworks. Culturally responsive care, including attention to military identity, moral injury, and diverse belief systems, is emphasized as a critical component of effective intervention. Finally, gaps in the current literature are identified, and directions for future research are proposed, with an emphasis on improving accessibility, enhancing intervention efficacy, and developing integrative, multidisciplinary approaches to suicide prevention among combat veterans.

Keywords

Suicidal Ideation, Combat Veterans, PTSD, Crisis Intervention, Military Mental Health, Veteran Suicide Prevention, Trauma, Peer Support

1. Introduction and Background

Suicide among U.S. military veterans remains a troubling public health concern that requires an in-depth comprehension and focused countermeasures. First Responders are not the only part of our population that is susceptible to suicide circumstances; veterans account for 8% of the population and yet make up more than 14% of adult suicides [18]. This wide discrepancy reflects the multitude of interacting factors that are specific to individuals who experience combat and military service-generated traumas. Combat veterans in particular face increased vulnerability during and after deployment associated with their combat-related stress exposure, physical injuries, moral injuries, and challenging reintegration into civilian life [9, 13].

The multifaceted nature of the contributing factors exacerbates the challenge of suicide prevention within this population. Veterans cope not only with diagnostic categories such

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as posttraumatic stress disorder (PTSD) and major depressive disorder but also with overlapping substance use disorders, traumatic brain injuries (TBI), moral injury, and social stressors, including estrangement from family and community supports [2, 14, 16]. Each of these influences alone is associated with increased suicide risk; combined, they create a heightened and urgent susceptibility [9].

Even the military setting influences risk and protective factors. Military personnel endure intense mental and physical training that builds resilience; however, these forces can also embed negative attitudes towards seeking help for mental health, which may restrain intervention seeking and outcomes [10]. Moreover, veterans often encounter challenges with reconnecting to civilian life; unemployment, loss of military peer-relationship camaraderie, identity dissonance, and limited access to culturally appropriate mental health services all form a breeding ground for distress and suicide [7]. More than half of veterans who endorse thoughts of suicide are not telling a healthcare provider or family, highlighting the need for identification and crisis intervention models [13].

Rates of suicide differ by subpopulations; for example, female veterans, younger veterans, and racial/ethnic minority veterans experience unique stressors and discrepancies in care access [10]. Female veterans are even worse off; in the same age group, their rate of suicide is close to twice that of civilians [18]. Minority veterans often encounter system-level barriers to care and are impacted by the intersectional stressors of trauma and discrimination associated with racism [7]. Likewise, it has been well-determined that LGBTQ+ veterans experience increased rates of suicidality related to stigma and lack of services tailored for their needs [13].

The higher rate of veteran suicides in recent years has driven national programs centered around evidence-based suicide prevention. The VA's National Strategy for Preventing Veteran Suicide [18] ensures that four goals are met in increasing early risk identification, access to crisis care, social and spiritual supports, and postvention [12]. In the Australian context, initiatives such as these suggest that, increasingly, there is a recognition that the solution to suicide prevention is systemic and must come from more than a reactive focus on the emergent mental health crisis of veterans but also change occurs in veterans' social and cultural experience [9].

While progress has been made in identifying individual risk factors, key gaps persist in terms of consistent implementation of intervention strategies across veteran populations and settings [9, 14]. Veteran suicide risk exists on a continuum that ranges from long-standing ideation for chronic mental illness to acute crises precipitated by life events or moral injury. A tailored, multidisciplinary crisis response is required [11]. In addition, research has shown that individuals who access culturally and spiritually congruent interventions become stronger in their protective factors and recovery; however, such alternative approaches are underutilized and require further investigation [11, 18].

The former is crucial in understanding higher suicide risk observed among those with combat experience (i.e., because depicting combat and particularly in comedic fashion, which can be necessary to maintain an individual's morale or esprit de corps) involves an approach to knowledge that incorporates clinical, social, cultural, and spiritual. The paper examines all these complex elements, ranging from mental health dynamics to the roles of first responders, how one must manage a crisis, and spiritual lessons that come with it, in addition to cultural commands. In bringing the evidence together, this paper seeks to inform those practitioners, policy makers, and researchers working within suicide prevention of veterans using evidence-based, comprehensive care.

2. Mental Health Dynamics and Symptoms

The mental health profile of the combat veteran presents a vital area for research to alleviate the prevalence of suicide-related ideation in this population. A major driver of the suicide risk lies in PTSD, which is one of several psychiatric ailments that veterans face. PTSD is characterized by intrusive memories, avoidance, negative mood, and cognitive changes, as well as increased arousal after experiences of trauma, including exposure to combat [4]. Suicidal ideation, attempts, and completions are significantly elevated in veterans with PTSD. One meta-analysis from Akbar et al. [2] recently quantified this risk and found that veterans with PTSD have a hazard ratio for suicide of approximately 7.1 relative to veterans without PTSD. The risk increases further in the presence of comorbid depression, with co-occurring PTSD and depression resulting in a hazard ratio exceeding [9, 14].

Veterans' depressive disorders often are characterized by high levels of hopelessness, anhedonia, and cognitive impairment, all of which increased risk for suicide independently [11]. A study by Martin et al. [11] reported that depression by itself leaves veterans with a weighted odds ratio of 6.51 in terms of suicidal ideation. Therefore, its identification and treatment are critically important. In addition, the confluence of PTSD and depression results in a multiplying effect that increases emotional pain and hinders coping.

SUDs (substance use disorders) are highly prevalent in veterans and markedly elevate the risk of suicide. Comorbid mental health and substance use issues, such as individuals with dual diagnosis/multi-morbidity of mental and substance use disorder(s), add further complexities due to impaired decision-making skills and greater tendencies towards impulsivity [13]. Research indicates the suicide rate for dually diagnosed veterans is greater than three times that of non-SUD veterans [8]. Alcohol was the most abused substance, which exacerbates depressive symptoms and treatment compliance comorbidly with it [8, 13].

The literature has also responded by elevating the role of moral injury as a central factor in understanding suicidality in combat vets. Afsharnejad et al. [1] described moral injury as:

the trauma experienced after doing or witnessing acts that one believes to be wrong according to their code of ethics and values, often encountered during military service. While PTSD has a fear-based component, moral injury is centered on guilt, shame, and an existential crisis. This is significant because moral injury may not be as responsive to standard PTSD treatments, but it also contributes significantly to suicidal ideation [3]. Treating moral injury requires holistic, clinical, and spiritual care that validates the profound struggle our veterans grapple with when they return from war.

There is a crucial role of life stressors in precipitating suicidal crises among veterans. More than mental illness, divorce, homelessness, joblessness, and social withdrawal are among the conditions that often contribute to attempts at suicide [12]. Family support networks or community connections would help alleviate feelings of alienation and despair. Ramchand et al. [13] highlights that the social determinants of health must be incorporated into clinical care if we are to have effective interventions to lower suicide rates. Thus, support mechanisms multi-(onto-)disciplinary for both mental health and socio-economic are essential in prevention and recovery.

Additionally, demographic dimensions play a role in suicidality. Women veterans traditionally have been underrepresented; however, they are increasingly reporting higher rates of suicide compared with civilian women, raising concerns about gender-specific stressors and the care gap [18]. Veterans of color encounter structural challenges and racism, which increases their risk [7]. Likewise, veterans of LGBTQ+ experience continue to face stigma in the military and post-military environment that exacerbates social isolation, as well as mental health problems [1].

Overall, suicidal ideation in combat veterans is fueled by complex mental health processes, specifically psychiatric disorders and substance abuse, mixed with moral injury and societal stress. A comprehensive evaluation and an integrated approach to risk profile reduction, along with adequate preventive interventions, are needed to lower risk and enhance resilience.

3. First Responders: Challenges and Recommendations

First responders play a critical and often underappreciated role in the identification and prevention of suicide among combat veterans. These professionals, including emergency medical technicians, law enforcement officers, crisis hotline staff, and social workers, frequently serve as the initial point of contact for veterans in acute suicidal crisis [3, 10].

An area of significant challenge for first responders is determining suicide risk in a military culture-specific situation. Veterans may experience an intricate constellation of clinical symptoms that are compounded by military-related phenomena, for example, trauma, moral injury, and help-seeking stigma [14]. Veteran-specific versions of specialized suicide risk screening measures, such as the Columbia Suicide Severity Rating Scale (C-SSRS), developed with veteran target populations, have been modified to increase depth of detection [6, 15]. Such instruments serve to effectively guide responders in gauging the severity and imminence of suicide risk so that crisis intervention can be delivered appropriately.

First responders who were exposed to high levels of traumatic and suicide exposure incidents over time were rated as experiencing more compassion fatigue, secondary trauma stress, and moral injury [10]. Such multiple and diverse cumulative stress exposure can have detrimental effects upon the mental health of responders, with consequent impact on their capacity to deliver high-quality care. Organizational responses to mitigate these impacts and build resilience among responders should include structured debriefings, implement mental health services, and promote peer support among its membership [6].

The rapidly evolving world of technology-aided care may hold a solution to some of the challenges facing veterans in rural areas. Telehealth services, including peer support interventions, have been found to increase access to crisis support and can address barriers such as those associated with distance or sociocultural norms [7, 13]. Virtual group safety planning and peer support are both very well-utilized and satisfactory among Veteran participants in pilot trials, representing a scalable approach to care during crises [7].

Staff members, including first responders and veterans, come together for mental health help. This is the crossing where the success rates of interventions skyrocket. Interdisciplinary teams, including those providing healthcare, chaplaincy services, social work, and peer support staff, conduct thorough assessments and wrap-around coordinated care for psychosocial determinants of suicidality [10, 13].

Training for first responders now needs to include trauma-informed care, military cultural competence, and best practices for suicide intervention and prevention. Training in these programs may also enhance the ability of first responders to engage with veterans, identify subtle signs of distress, and intervene effectively in a crisis [3, 14].

However, there are still practice inconsistencies, as well as a lack of backing from agencies. Future efforts must allocate additional resources, policy attention, and research leading to evidence-based first-responder interventions to improve the quality of care and reduce suicidal behavior in veterans [6, 18].

4. Best Practices in Crisis Intervention

Effective crisis response for suicidal combat veterans requires evidence-based, timely, and culturally sensitive interventions that recognize the immediate risk while promoting sustained recovery and resilience. Several studies also emphasize the significance of multidisciplinary and systematic crisis response methods that include clinical, social-emotional, and spiritual aspects of care.

5. Suicide Risk Assessment and Screening

Identification of suicide risk in a stepwise manner using evidence-based screening instruments is necessary. Suicide ideation severity, intent, and past behavior can be classified using instruments such as the Columbia Suicide Severity Rating Scale (C-SSRS) to help guide urgency and type of intervention [6, 14, 15]. Related screening and methods (i.e., access to guns or other lethal means) are a crucial part of effective suicide prevention, given that nearly 70% of veteran suicides are firearm related [18].

Crisis Response Planning (CRP)

Crisis Response Planning (CRP) has received substantial empirical support as a brief, structured intervention targeting the reduction of suicide attempts. CRP involves collaboratively creating reflective warning signs and action suggestions (coping strategies, social contacts) for breaking suicidal crises [1, 9]. CRP participants show clinically significant decreases in suicidal ideation and attempts, suggesting that it is an appropriate acute suicide prevention intervention for veterans.

Trauma-Focused Psychotherapies

Trauma-informed psychotherapies such as cognitive processing therapy (CPT) and prolonged exposure (PE) would help to target PTSD symptoms that drive a substantial portion of veterans' risk for suicide, particularly with symptom resolution from CPT/PE, but it is also likely to have an impact on suicidal ideation [11, 16]. The timely treatment of and adherence to such therapies are associated with a reduced acute risk of suicide. By integrating these treatments within crisis-intervention frameworks, prompt symptom reduction is achieved while ensuring safety-oriented planning and management.

Peer-Supported Telehealth Programs

New telehealth technology has, in turn, created ways to expand access to crisis intervention, particularly for rural or movement-inhibited veterans. Compared to treatment as usual, peer-led telehealth safety planning groups have shown higher engagement rates and reduced suicidal ideation [8, 13]. The Middle East and Afghanistan represent fertile ground for such models that rest on the credibility of shared military service, combined with digital ease.

Lethal Means Counseling and Safety Enhancements

Given the high prevalence of firearm suicidality among veterans, lethal means counseling is a core risk management strategy. The other is related to the value of "safe storage, who to remove temporarily, and with whom to consult" [12, 18]. Studies have indicated that restricting a suicidal person's access to lethal means in a crisis can reduce the risk of suicide.

Integrating Multi-Professional and Social Services

For many veterans in crisis, it is a blend of complex problems that are not just about mental health; this could include housing instability, financial woes, or legal troubles. Multidisciplinary crisis intervention, encompassing clinical, social work, legal aid, and faith-based services, provides better support for veterans' stabilization [10, 13]. This data aligns with the view that vets express, which is that they want an integrated support system.

Postvention and Community Outreach

Postvention services that address grief and trauma following a suicide attempt or death are to prevent contagion and assist with survivor recovery in veteran communities [12]. School-based initiatives that educate families and peers about warning signs, the importance of early identification, and available support can promote early intervention.

Spiritual Applications and Scriptural Integration

The importance of spirituality and faith for addressing suicidal ideation and promoting mental health in combat veterans is increasingly acknowledged in clinical and community-based environments. Spirituality provides a framework through which veterans may derive meaning, hope, and resilience amid severe distress [3, 7]. Several studies have shown that involvement in faith-based communities, the use of chaplain services, and spiritual counseling can buffer against the risk of suicide when offered within traditional mental health treatment [11, 18].

The scriptures of the faith and its numerous religious observances are essential sources of solace and strength for many veterans. Pastoral care often draws on Psalm 34:18 ("The Lord is close to the brokenhearted and saves those who are crushed in spirit," [5, 17] during times of acute crises, as this verse offers comfort as well as hope [6]. This passage serves as a testament to the larger function of bringing comfort and a sense of divine presence to someone wrestling with hopelessness.

Religion-based interventions focus on unconditional acceptance that lets veterans verbally process their spiritual struggles and moral injury without fear of judgment [11] helping to alleviate the existential and spiritual pain that undergirds suicide risk among veterans. Trauma-informed care-trained chaplains adjust their tactics to align with evidence-based practices, resulting in holistic paradigms of healing that are inclusive to all belief systems [18].

Additionally, veterans who are religious community members are also found to have lower suicide rates; this effect is partially mediated by social integration, pro-social values, and spiritual coping [3]. Most significantly, the religious community can provide much-needed social support, alleviating loneliness through association and camaraderie.

But an understanding of spirituality requires something to balance it with cultural humility and respect. Those veterans' beliefs and practices are diverse, and it may be that they do not all arrive at faith in the aftermath of traumas. Therapeutic transparency and mutual spiritual pain inquiry are necessary to counteract disempowerment and foster engagement with [7].

The unrestricted use of spiritual applications in crisis interventions should include an equal personalized presentation that honors one's personal belief system and affects the healing potential and serves as a buffer against suicide.

Cultural Considerations

Cultural considerations are essential to successfully prevent suicide in combat veterans. Veterans are not a monolithic group; instead, they are diverse in terms of gender, race and ethnicity, sexual orientation, geography, and military experience [10, 13]. These various identities impact the everyday lives of veterans struggling with mental health concerns, receiving treatment, and interacting with crisis response.

Gender and Suicide Risk

Although women veterans are a tiny part of the population, they have experienced higher and increasing suicide rates and have specialized care needs [18]. Gender specific stressors, including exposure to military sexual trauma, burden of caretaking responsibilities, and amplified stigma related to mental health, contribute to increased vulnerability among women veterans [9]. Women veterans are also less likely to have timely access to mental health care, and thus there is a need for gender-specific outreach and engagement programs [10].

Racial and Ethnic Minority Veterans

Veterans who are from racial or ethnic minority communities face compounding difficulties due to structural inequities as well as systemic disparities in the ability to access health care [7]. Tensions of trust and cultural misunderstanding with healthcare providers were prevalent among the veterans, acting as a barrier to care regarding engagement with suicide prevention services [13]. Community-led and culture-bound interventions are more acceptable and effective [2].

LGBTQ+ Veterans

LGBTQ+ veterans are a historically marginalized population, with increased mental health disparities including higher rates of suicidal ideation and attempts [13]. The double-edged sword of discrimination in the military cuts through both the military and civilian world, as such soldiers require inclusive, affirming crisis supports tailored to address special challenges manifest from sexual and gender identity [10].

Rural Veterans

Rural-based veterans are particularly affected by geographical distance and lack of access to mental health treatment and crisis intervention services. Telehealth and mobile outreach have been proposed as potential solutions to address these gaps but are not without their challenges in terms of infrastructure and technology [7]. Culturally responsive and peer-led crisis interventions have been effective in rural environments [13].

Military Culture and Stigma

In military culture, toughness, self-reliance, and mission orientation are core values that may influence the intention to seek mental health care [10]. There is a mental health stigma and suicide stigma, which may cause veterans to conceal their distress, thus crises are not laid bare. Veteran & Culture (VetC) focused interventions are services that rely on veteran-specific language and approaches, which respect veterans' service and reject negative beliefs (e.g., stigma) about seeking care by promoting engagement [11].

To develop suicide prevention efforts that are equitable, respectful, and effective for all veterans, training, policy work, and community partnerships must be responsive to these cultural factors.

6. Conclusion

The complex issue of suicidal ideation among combat veterans is the result of multifaceted and interrelated mental health, social, spiritual, and cultural factors. Elevated suicide rates in this population reflect the burdens of trauma-related disorders, moral injury, substance misuse, and significant life stressors. The study questions how suicide prevention can be comprehensive and concludes that it must be a combination of clinical therapies with evidence demonstrated and culturally accommodating practices. First responders and mental health professionals need specially trained personnel to recognize and respond effectively to Veterans' needs. Peer-led programs and telehealth technologies have shown promise in enhancing access and participation, especially among rural and underserved communities. In fact, around-the-clock (ATC) services are necessary so that treatment can be responsive to crisis calls from youth. Collaborative, integrated care involving social services, faith communities, and healthcare providers is necessary to address both immediate risk and root causes of suicidality.

7. Ideas for Future Research

Although progress has been made in understanding the risk, several knowledge gaps remain and should be targeted for research. Prospective longitudinal studies of long-term outcomes for telehealth and peer support interventions on suicide-specific outcomes in diverse subpopulations of veterans should be a priority for future research. Exploring the intersections of moral injury and spiritual distress is a crucial topic that deserves both qualitative and quantitative investigation to enhance integrative models of care. Sex-specific efforts are an essential component of addressing differential risk profiles and service needs among women veterans. Studies of those from marginalized groups (e.g., racial and sexual minorities, veterans with lesbian, gay, bisexual, or transgender orientation) or from rural areas can inform culturally tailored approaches for crisis intervention. Finally, examining the transition period from active service to civilian life can help identify targeted strategies to reduce the "deadly gap" where suicidality spikes—understanding systemic and policy barriers that narrow access to care will further enhance prevention efforts.

Abbreviations

ATC	Around the clock
C-SSRS	Columbia Suicide Severity Rating Scale
SUD	Substance Use Disorder
VetC	Veteran and Culture

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Tracy L. DuShane: Conceptualization, Formal Analysis, Writing- original draft, Writing – review & editing

Conflicts of Interest

The author declares no conflicts of interest.

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