nondiscriminatory care and to serve all classes of patients. The American Medical Association’s Principles of Medical Ethics calls for physicians to support access to medical care for all people.

RECOMMENDATIONS

What measures can we take to improve treatment access of individuals with opioid use disorder who are trying to access the most effective treatment of their condition? Each of us can examine our own practices and work to ensure inclusion of the most vulnerable. Professional medical organizations and medical societies could have clear policies against this type of practice. A universal expansion of medication treatment through the roughly 1400 federally funded US community health centers could effectively provide affordable access for many. State mental health agencies could move toward the funding and establishment of not-for-profit medication treatment programs. Loan repayment programs could be structured for physicians, physician assistants, nurse practitioners, and substance use counselors who are trained in addiction medicine and then receive loan repayment contingent on practicing in nonprofit settings. We urgently need good data on reimbursement policies among nationwide buprenorphine treatment programs to tailor policies that address the problem. More initiatives may come to light through the work of individuals dedicated to removing barriers and ensuring access for everyone to this much needed and effective treatment, which would help to save lives, improve social functioning, reduce criminal behavior, and decrease HIV and hepatitis C transmission.

Art Van Zee, MD
David A. Fiellin, MD

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CONFLICTS OF INTEREST

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ABOUT THE AUTHORS

At the time this editorial was written, Pauline Lubens was with the Program in Public Health, University of California, Irvine. Roxane Cohen Silver is with the Department of Psychological Science, the Program in Public Health, and the Department of Medicine, University of California, Irvine.

Correspondence should be sent to Pauline Lubens, Lecturer, Santa Clara University, Public Health Program, Kenna Hall 110D, Santa Clara University, 500 El Camino Real, Santa Clara, CA 95053 (e-mail: plubens@scu.edu). Reprints can be ordered at http://www.ajph.org by clicking the “Reprints” link.

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Grief in Veterans: An Unexplored Consequence of War

Since the wars in Afghanistan and Iraq began in 2001 and 2003, respectively, more than 5400 US military personnel have died in combat.1 Embarking on a military combat career brings an intrinsic risk of injury, mortality, and the death of comrades. Increasingly, however, US military personnel are facing the added burden of losing comrades to self-inflicted wounds, most of which occur after troops return home from deployment.2 Indeed, as the number of troops killed in action has declined, the military suicide rate has at times surpassed the combat casualty rate. In a 2017 Iraq and Afghanistan Veterans of America survey, 58% of participants indicated that they knew a veteran who died by suicide, and 65% indicated that they knew a veteran who had attempted to take his or her own life. Not only does the military suicide rate currently exceed the combat death rate, but the military suicide rate now exceeds the civilian rate.3

This loss of life may have serious consequences for the health and well-being of surviving veterans. In fact, grief in veterans may well have the same status as posttraumatic stress disorder (PTSD) did in the aftermath of the Vietnam War: largely overlooked. Although there is ample research about the psychological toll of war, much of it has focused on the association between combat exposure and PTSD, depression, and alcohol use and abuse.4 The limited research on grief that has been conducted among the military community has focused primarily on bereaved military families.5 Moreover, even public pronouncements on Memorial Day focus almost exclusively on the families of the fallen, ignoring the grief of the troops who served alongside them.

An exhaustive literature search for studies of grief among military personnel who lost comrades in battle yielded only a few studies that explored grief in Vietnam era combat veterans,6 and these were conducted decades after the war ended. In addition, to our knowledge there is no research that has considered whether grief is a distinct outcome from PTSD in combat veterans. Thus, although we know a little about veterans’ grief responses to battle deaths during
the Vietnam War, we know virtually nothing about post-9/11 veterans’ grief responses to losing comrades—especially to suicide. Moreover, the military literature is silent on whether there is a distinction between grief over a comrade’s combat death and grief over a comrade’s suicide. These research gaps have important consequences for veterans’ mental as well as physical health.

Although there is limited grief research conducted among the military, research from the civilian community can serve as a guide. Studies conducted among civilians suggest that grief responses are quite variable and can depend on both the circumstances and the mode of death. Research also suggests that social support and the quality of the survivor’s social network may be predictors of grief severity across modes of death. Finally, some researchers have attributed the difference in grief response to whether a death is expected or unexpected, and they have classified both violent deaths and suicide as unexpected. Indeed, studies of responses to death in the civilian community have drawn distinctions between loss to suicide and to other forms of death, with suicide loss resulting in greater guilt, perception of responsibility, anger, and a sense of abandonment. However, we might inquire whether suicide and combat deaths are equally unexpected in the military. In the context of war, where death is intrinsic and those who wage the battles can be expected to be directly in the line of fire, combat deaths may be considered relatively expected but may nonetheless be more distressing because of survivor guilt. By contrast, military suicide deaths—particularly those that occur after troops have returned home—may be comparatively unexpected and thus more distressing for combat veterans.

We recently completed a mixed-methods study of US combat veterans of the wars in Iraq and Afghanistan who had experienced the loss of comrades by suicide, by combat, or by both modes of death (Lubens and Silver, unpublished). Our results tell a complex story about how combat veterans experience the deaths of their military comrades and the predictors of grief. Results suggest that the level of acceptance of a comrade’s death depends on the mode of death, with combat deaths being easier to accept than suicide deaths. Interviews with more than two dozen veterans suggest that they perceive combat deaths as expected and meaningful, and thus easier to accept, but they perceive suicide deaths as unexpected and more difficult to accept. Veteran interviews also suggest that both modes of death provoke blame and anger directed at whoever killed their comrade—opposing forces in combat or their comrade him- or herself in the case of suicide. In addition, even though combat exposure is a well-studied predictor of PTSD symptoms, results of a survey of almost 200 veterans suggest that combat exposure plays an important role in understanding veteran grief. Also, unit cohesion in the military is a form of social cohesion and plays a role in how veterans grieve the deaths of their comrades, either in combat or after they return home.

To our knowledge, ours is the first study to explore grief over both combat and suicide deaths among US combat veterans. Although we did not find that years since loss explained the level of grief, future research might explore the impact of time since loss to distinguish between acute and complicated grief from both forms of loss. The more we can delineate the distinct toll of suicide and combat loss among the current generation of veterans, the better we can minimize the public health impact of the most recent US wars. Also, veterans’ postwar health outcomes undoubtedly cascade to their immediate and extended families as well as their broader communities. Insight into the toll of these losses may inform interventions that enable families to recognize the consequences of grief and to acknowledge grief in veterans as a postwar malady distinct from PTSD. We know that scholars have explored moral injury in the context of combat service; further study of the role of moral injury in suicide deaths would serve to delineate war’s effects.

When a war ends, the battle begins. It is our responsibility as public health scholars and researchers to provide the necessary tools to minimize the severity of war’s toll. Addressing veteran grief over loss of comrades is likely to be vital to meeting this goal and deserves more attention than it has thus far received. Veterans may have survived the incidents that killed their comrades and may have returned home from their deployments physically intact. However, they may continue to battle demons left behind by those losses. And many will eventually lose the battle on the home front. The latest Veterans Affairs report about veteran suicide, released in September 2018, revealed that the suicide rate for veterans aged 18 to 34 years increased more than 10% between 2015 and 2016. There is little doubt that this increase in suicides among younger veterans will increase the emotional toll on their grieving comrades.

We have seen the public health consequences of the Vietnam War reflected in the faces of many of the nation’s homeless—a condition brought on largely by PTSD, other mental illnesses, and the substance abuse that for many veterans began in the jungles of Vietnam. But what we may also see reflected in the faces of recent veterans is the failure to explore all possible consequences of their service in combat.

Pauline Lubens, PhD, MPH
Roxane Cohen Silver, PhD

CONTRIBUTORS
Both authors wrote the editorial.

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