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# Narrating Veteran Trauma, Suicide, and the State: From the Korean War to the War on Terror

ORIGINAL RESEARCH

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## ABSTRACT

Since 1980, when posttraumatic stress disorder (PTSD) was included for the first time in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), stigmatized notions of shell shock and combat fatigue have given way to broader and more nuanced clinical understandings and greater public awareness of veterans' mental health struggles. How this changing social context has shaped how diverse veterans narrate their understandings of military service-related trauma, mental health struggles, and suicide, however, remains unknown. In an attempt to shed preliminary light on this question, this interdisciplinary paper used mixed methods to trace how clinical, academic, and popular understandings of both veteran trauma and suicidality, as well as understandings about the role of the state in intervening to mitigate suicidality, have changed since World War II.

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bureaucratic stigma; narrative inquiry; posttraumatic stress disorder (PTSD); veteran identity; veteran suicide

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In the United States today, military veterans' trauma and mental health struggles are generally understood as worthy of sympathy and support. Many Americans also believe that the government bears at least a degree of responsibility for providing mental health services and other resources, through the Department of Veterans Affairs (VA) and other state entities, to mitigate veterans' elevated risk of suicide. However, these widely accepted understandings of veterans' trauma, suicidality, and the state are relatively new. It was not until 1980, with the inclusion of posttraumatic stress disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980)[1] that stigmatized notions of shell shock and combat fatigue would diminish sufficiently to allow clinicians, scholars, and veteran activists to break the silence surrounding the issue of veterans' mental health. As a result, in the past 50 years, the provision of mental health services and suicide interventions to veterans has expanded dramatically, especially in the post-9/11 era. At the same time, growing public awareness has allowed for broader and more nuanced conversations about the causes and contexts of veteran trauma and suicide. To date, though, little is known about how this changing social context has shaped the ways that diverse veterans and their loved ones understand these phenomena.

As a preliminary step toward filling this gap in the literature, this paper uses narrative inquiry and descriptive statistics to examine how four era cohorts of veterans narrate their understandings of trauma, suicide, and the state. These four cohorts were Korean War, Vietnam War, First Gulf War, and War on Terror.[2] After briefly discussing how clinical, academic, and popular understandings of veterans' trauma, mental health, and suicide have changed in the post-World War II era, we analyze oral histories archived in the United States Library of Congress Veterans History Project to generate new insight into how veterans of the Korea, Vietnam, and post-9/11 Iraq and Afghanistan eras narrate experiences with military service-related trauma, mental health struggles, and suicide. In particular, we seek to trace the extent to which the narratives of veterans in these four era cohorts reflect evolving clinical, academic, and popular understandings of veteran mental health; shifting values and emotions around notions of trauma and suicide; as well as changing beliefs about the role of the state in providing care and support for distressed veterans. Through this analysis, this paper sheds preliminary but provocative new light on how ideas about combat trauma and veterans' mental health are influenced by historical and social contexts, and how these external forces shape how former servicemembers and their loved ones narrate their experiences of trauma and suicide.

In line with the *Journal of Veteran Studies*' framework for defining veteran identity, this study defines a veteran as any individual who has a record of active military service within a branch of the United States Armed Forces, and focuses on their experience after having separated from the military (Grohowski, 2016; Lira & Chandrasekar, 2020). This definition encompasses both legally designated veteran status (individuals discharged under conditions other than dishonorable) and self-designated veteran identities tied directly to an established record of military service, allowing for the analytical inclusion of complex or historically marginalized experiences of military service.

## RESEARCHER POSITIONALITY

Because narrative inquiry understands interpretation as shaped by the experiences researchers bring to their analysis (Clandinin & Rosiek, 2019), we note that all four authors are connected to military service. Dr. Anita Casavantes Bradford, a historian and director of the University of California (UC) Irvine Veteran Studies Certificate program, is a military spouse and the daughter of a Korean War veteran and prisoner of war. Harwood Garland, a doctoral student in Population Health and Disease Prevention at UC Irvine and served as a US Navy hospital corpsman. Jason Lee is a UC Irvine graduate, US Army Sergeant, and medical school applicant, and Francisco Munoz is a UC Santa Cruz graduate, Marine Corps veteran, and Los Angeles County Veteran Service Officer who assists veterans with VA claims. This shared proximity to military life sharpens our reading of military idiom and of veterans' encounters with the state and provides a foundation for our analysis of military cultures; but it also risks leading us to take military assumptions for granted or to read our own experiences into narratives from other eras and branches. We addressed these potential biases through in-depth discussion of our diverse experiences and understandings of military service branches, roles, subcultures, and eras; of the assumptions and values of our scholarly disciplines and professional practices; and of how our racial, classed, and gendered identities shape our perspectives. We also sought to mitigate potential biases through team training sessions, collective review of individual analyses, and by implementing an Era Data Richness Indicator tool to assess the consistency of our analysis across era cohorts.

## SETTING THE STAGE: A BRIEF HISTORY OF MILITARY VETERANS, TRAUMA, AND MENTAL HEALTH

In the United States and other industrialized Western societies today, military veterans' mental health struggles—and PTSD more broadly—are widely viewed as legitimate, adaptive psychological and neurobiological responses to shocking events such as wartime violence, sexual assault, or disaster. This contemporary framework recognizes a wide symptom pool, ranging from intrusive memories and emotional dysregulation to somatic ailments like headaches and nausea. Public consensus accordingly views trauma victims as deserving of sympathy, and positions the state—via institutions like the VA—as responsible for providing clinical interventions to mitigate elevated suicide risk. Yet as Didier Fassin and Richard Rechtman (2009) note, this sympathetic, institutionalized understanding of trauma is a historically recent paradigm shift, one that would have made little sense to most people prior to the 1980s.

Industrialization facilitated the expansion of mass transportation, particularly railways. The accompanying rise in railway accidents brought increased attention to the physical and psychological consequences of traumatic events. The resulting cases provided new opportunities for clinical observation and study. An important development in this history occurred in 1867, when British physician John Eric Erichsen summarized this rise of industrial accidents and examined the symptoms experienced by survivors of railway accidents. He described symptoms including depression, numbness, pain, and memory disturbances, some of which could not be readily explained by identifiable anatomical lesions. Erichsen attributed at least some of these conditions to occult lesions of the spinal column (Erichsen, 1867). German neurologist Hermann Oppenheim expanded on the idea, arguing that traumatic symptoms resulted from organic changes in the brain (Holdorff, 2011). By the turn of the twentieth century, European medical professionals increasingly understood trauma in psychological terms—first to describe "sinistrosis," a condition that prevented factory workers (many of them immigrants) from returning to work after industrial accidents, and then to describe women suffering from "hysteria." These deeply raced, classed, and gendered diagnoses cast suspicion on both the definition of trauma and the person claiming to suffer it.

During World War I, European military psychologists deployed this same stigmatizing notion of trauma to treat the "neuroses" of servicemembers damaged by exposure to wartime fear and violence. Like sinistrosis sufferers, soldiers were suspected of simulating "shell shock" to avoid returning to the battlefield. The war compelled some psychologists to accept that Caucasian men were as susceptible to trauma as women and non-Caucasian people, yet it continued to be understood in stigmatized terms—as evidence of a lack of patriotism, sexual degeneracy, or moral failure (Adler, 2017). Reflecting these understandings, the US Veterans' Bureau—established in 1921 to administer benefits to those who served in the war—did not regard service-related psychological harm as a medical condition, nor did it acknowledge any government obligation to care for veterans afflicted by it. Beyond helping returning servicemembers find employment, the Bureau's own leadership was divided over whether to provide the financial "bonuses" mandated by the 1924 World War Adjusted Compensation Act (Ortiz, 2010).

These taboos continued to work against clinical understanding of combat fatigue during World War II. The newly consolidated Veterans Administration occupied itself primarily with administering pensions and overseeing burials, neither tasked with nor concerned with supporting veterans affected by service-related trauma. As a result, World War II veterans struggled alone and in silence with the scars of war; neither they nor the 1.5 million veterans who served in Korea between 1950 and 1953 received federally funded healthcare (Himmelstein et al., 2007). Their psychological suffering remained largely unacknowledged, or at best understood as a personal weakness to be endured stoically.

The tide was nonetheless beginning to turn: postwar psychoanalytic studies of Holocaust survivors diagnosed with concentration camp or survivor syndrome stimulated growing public sympathy for trauma victims, even as the VA itself expanded to meet the needs of demobilized World War II veterans, then again in the 1950s for veterans of Korea. In 1953, the VA reorganized its services into the Department of Medicine and Surgery, the Department of Veterans Benefits, and the Department of Insurance—forerunners of today's Veterans Health Administration and Veterans Benefits Administration (Matos, 2021).

It was not until the 1970s that two key developments redefined how Americans understood veterans' trauma. First, activism on behalf of Vietnam veterans suffering illnesses caused by exposure to the herbicide Agent Orange forced the federal government to acknowledge its responsibility for post service medical care (Scott, 1993); in response, the establishment of the Veterans Health Administration linked military service and federally funded healthcare to a previously unprecedented level (Martini, 2010). Second, American anti-war activists, social workers, and psychiatrists campaigned to raise awareness of Vietnam veterans' postwar distress and to compel clinicians to recognize it as a legitimate psychological disorder rather than a personal battle to be waged in silence. This campaign converged with feminist activism on behalf of survivors of domestic and sexual violence

to transform both clinical and popular understandings of trauma, culminating in 1980 with the inclusion of post-traumatic stress disorder (PTSD) in the DSM-III (American Psychiatric Association, 1980).

PTSD's formal recognition represented a watershed moment. The age-old condition's new status as a diagnosable illness sparked an explosion of psychiatric research, epitomized by Bessel van der Kolk's (2014) seminal text, *The Body Keeps the Score*, and led to the founding of specialized journals, including the *Journal of Traumatic Stress*, established in 1988. A new understanding of the relationship between military service and mental health also emerged from a 1986 landmark study by Hearst et al., which found dramatically higher suicide rates among the draft-eligible population, firmly establishing military service as an exacerbating factor in suicidality. When the VA—the new Cabinet-level department established in 1988 to replace the Veterans' Administration—confirmed PTSD's diagnostic status, it laid the foundation for modern research into veterans' trauma and suicidality, as well as the clinical justification for activists' insistence that the federal government was obligated to provide mental health services to former servicemembers in distress.

Changing clinical understandings were accompanied by popular culture representations of veterans' trauma and suicide. Films of the late 1970s and early 1980s—including *The Deer Hunter* (1978), *Coming Home* (1978), and *Rambo* (1982)—served to raise public awareness and inspire new empathy for those suffering from PTSD (Lembcke, 1998). Yet these and other cultural texts relied on a limited range of racialized and gendered tropes, representing white male veterans as either psychologically broken victims or as tragic figures enduring their pain in stoic silence (Hagopian, 2013). These depictions reflected the persistence of stigmas surrounding mental illness, as well as notions of masculine endurance and reticence that continued to shape both military and civilian culture.

In the aftermath of 9/11, legislation including the Joshua Omvig Act (2007) and the Clay Hunt SAV Act (2015) marked a major increase in federal support for veteran mental health. A pivotal regulatory shift followed in 2010, when the VA removed the requirement for objective combat corroboration, allowing veterans' own testimony to establish a PTSD stressor related to "fear of hostile military or terrorist activity," (Stressor Determinations for Posttraumatic Stress Disorder, 2010, p. 39843), without independent corroboration—a change that expanded access to comprehensive care and financial compensation (Yarvis 2013). The growing institutionalization of PTSD as a medical disorder has further destigmatized veterans' mental health struggles, even as new discussions of military sexual assault and veteran homelessness have raised public awareness of the psychological costs of military service for more recent generations of veterans.

## SCHOLARLY PERSPECTIVES ON VETERANS' TRAUMA, SUICIDALITY, AND THE STATE

In the decades following the wars in Iraq and Afghanistan, clinical awareness of veteran mental health challenges—especially PTSD, traumatic brain injury, and suicide risk—has expanded dramatically. Fulton et al. (2015) found that approximately one-quarter to one-third of post-9/11 veterans had experienced PTSD at some point, prompting significant institutional attention to diagnosis and treatment (Fulton et al., 2015; Institute of Medicine, 2014). Similarly, the growth in clinical attention to veteran suicidality reflects the higher rates of suicide among post-9/11 veterans (Moceri-Brooks et al., 2023).

As part of efforts to understand the causal factors driving this trend, recent epidemiological studies have documented the complex associations between PTSD and suicidal behaviors among US veterans. A systematic review by Holliday et al. (2020) emphasized the complexity of veteran suicide, noting that while PTSD is significantly associated with suicide attempts, findings remain mixed for ideation and completed suicide. This highlights the critical need to explore how clinical conditions intersect with broader risk factors. Explaining veteran suicide requires looking beyond isolated PTSD toward a combination of psychological, social, and cultural factors. Specifically, depression mediates the PTSD-suicidal behavior relationship in post-9/11 servicemembers (Kuzmina et al., 2023), while social determinants like economic hardship and limited healthcare access heavily drive risk (Pietrzak et al, 2026). Furthermore, military and masculine norms prize emotional stoicism and self-reliance, which simultaneously intensifies PTSD symptoms and discourages veterans from seeking treatment (Neilson et al., 2020; Silvestrini & Chen, 2023). Thanks to this research, we now have a much greater understanding of the symptoms and risk factors that influence veteran trauma and suicidality. However, there remains a notable gap in the clinical literature on how these are experienced and interpreted by veterans themselves.

Veterans' own stories have been collected in archives, anthologies, memoirs, and creative projects. An example is Chesty B. Puller Jr.'s *Fortunate Son* (Puller, 1991), which describes the ordeals of a veteran severely wounded during the US Vietnam War. More recently, *Operation Homecoming* (Carroll, 2006) compiled post-9/11 veterans' own writings on fear, loss, identity, and reintegration, illustrating how

narrative expression serves both therapeutic and political functions. Veteran studies scholars, including Travis L. Martin (2022), have similarly examined what coming home means for US veterans who served in Iraq, Afghanistan, and other post-9/11 operations; drawing on his own military service, Martin critiqued dominant cultural narratives like those of the hero and the wounded warrior that continue to shape public, institutional, and even academic understandings of veterans' diverse individual experiences. Another recent study explored how Iraq and Afghanistan combat veterans use personal storytelling platforms like YouTube vlogs to create their own narrative spaces, addressing themes of loss, help-seeking, guilt, shame, and connection in ways that similarly contest clinical or popular media narratives (Schuman et al., 2019).

Scholars have also begun to explore how veterans' understandings of trauma and suicide shape or are shaped by the social contexts in which they are created, consumed, and contested. A recent study by Roscoe, Riles, and Schroeder (2024) found that veterans' exposure to news portrayals of military-related post-traumatic stress significantly shapes how they perceive themselves, other veterans with PTSD, and the legitimacy of government health interventions, with stigmatizing media messages exerting stronger influences than prosocial ("halo") messages. Fox (2021) similarly explored how American veterans draw upon notions of patriotism, loyalty, sacrifice, and national identity to narrate experiences of military-connected suicide. Emphasizing how veterans make sense of suicide through symbolic and cultural frameworks tied to national narratives, she traces post-9/11 veterans' growing demands that state and society acknowledge the long-term effects of military trauma and fulfill its obligations to care for veterans' mental health.

At the same time, other studies suggest that stigmas related to veteran trauma and suicide persist within state institutions, and that they continue to shape how veterans understand and narrate their experiences. Roscoe (2023) found that veterans seeking treatment for PTSD still often experience stigmatizing interactions within the VA, where military values such as stoicism and emotional control continue to be prized. K.C. Hooyer (2022) similarly found that post-9/11 veterans continue to experience moral judgment and suspicions of malingering when attempting to claim mental health-related disability benefits. Hooyer also found that the repetitive recounting of personal trauma to VA personnel—a process they describe as the "trauma pitch" ("The Trauma Pitch," para. 2)—can itself become a source of distress, and that it might reinforce veterans' perceptions of institutional suspicion and complicate their efforts to access treatment or resources. Studies like these provide important insight into how veterans narrate experiences of violence, grief and trauma. They also speak to the ways veterans articulate moral injury, a term that refers to the lasting psychological, spiritual, behavioral, and social harm that can follow perpetrating, failing to prevent, witnessing, or learning about acts that violate deeply held moral beliefs, or being betrayed by a legitimate authority in a high-stakes situation (Litz et al., 2009; Shay, 2014).

They also shed important light on the interaction between veterans' shifting understandings of trauma and suicide and the broader contexts in which they occur. However, most do not situate veterans' discursive practices within the shifting clinical, political, social, and cultural contexts that shape how narratives of veterans' trauma and suicidality are created, consumed, and contested. Nor do they address how veterans' narratives parallel or diverge from those of servicemembers from previous eras. Because they fail to locate veterans' narratives within time or to compare them with those of previous generations of warfighters, scholars to date have failed to consider how veterans' inner worlds—as revealed through narrative—intersect with their external lived realities. In order to address this omission, this paper places oral histories from the Korea, Vietnam, and post-9/11 eras in conversation with their historical moment and with one another, bridging the clinical, social, and personal domains in order to shed new light on how diverse groups of veterans have narrated their own and others' experiences with trauma, suicide, and the state over time.

## METHODS

This study used narrative inquiry and descriptive statistics to analyze oral histories from the Veterans History Project. This dataset within the Library of Congress contains extensive collections describing US military veterans, including 15,744 interviews (audio, video, and text). A keyword search for the term "suicide" returned 151 interviews. When available in the Library of Congress dataset, information on the veteran's military branch, service years, location of service; highest rank achieved; gender, and race/ethnicity were added to our dataset descriptors. As our focus was post-World War II transitions, we included only records of veterans who had served between the Korean War and the War on Terror (n = 49). We assigned each of these veterans to one of four 'eras' of service, which we categorized as:

- Korean War Era cohort (1950–1964),
- Vietnam War Era cohort (1965–1990),
- First Gulf War Era cohort (1991–2002), and
- Post-9/11 / War on Terror Era cohort (2003–2025).

Members of the research team then watched and analyzed these interviews, using a checklist to catalog 16 descriptors of the veteran's experience with trauma, suicidality, and the state. These descriptors tracked veterans' mentions of traumatic experiences and trauma; allusions to shame, stigma, or unwillingness to discuss these issues; personal weakness as an explanatory factor for mental health struggles and/or suicide; as well as if/how the veteran linked those experiences with trauma and/or suicidality to the government or other state-directed institutional resources. We also tracked veterans' references to race/ethnicity, socioeconomic status (SES), gender, and sexuality, and any associations they made between those factors and trauma and/or suicidality. Each interview was analyzed by one member of the research team. To ensure consistency, we held a preliminary training session to discuss how selected excerpts from the narratives reflected/did not reflect the checklist descriptors, and individual analyses were presented and discussed at subsequent research team meetings. Rather than statistically significant conclusions in their own right, the descriptive statistics generated through this process are intended to provide a broader context for the study, as well as to assist in identifying recurrent themes and trends to be explored in the narrative analysis portion of the paper.

We also conducted a "deep dive" narrative inquiry analysis of eight interviews drawn from across our four era cohorts: two each for the Korea, Vietnam, First Gulf War, and post-9/11 groups. These interviews were selected both because they contained rich discussion of the topics of trauma, suicidality, and the state, and for being broadly representative of the kinds of narrative frameworks and strategies we identified in the dataset as a whole. We analyzed these selected interviews using the method of narrative inquiry, a qualitative, cross-disciplinary research methodology that emphasizes the importance of oral narrative research in uncovering how people construct meaning through stories (Connelly & Clandinin, 2006; Delgado, 1989, 1995; Hurwitz et al., 2004).

As an approach, narrative inquiry is sensitive to the ways that socially constructed and stratified identities and positionalities, including race, ethnicity, class, gender, sexuality, national origin, and citizenship status inflect individuals' identities, values, aspirations, and ways of communicating (Collins, 1986; hooks, 1989; Hurtado, 1989; Pesquera & Segura, 1993), shaping individual experiences and how they are articulated. To these, we as scholars of veteran studies add other important and military-specific identities and positionalities, including branch of service, rank, military occupational specialty (MOS), combat versus non-combat-deployed experience, and generation/theater of war, that are salient to many veterans. However, while recognizing the ways that historical social context shapes participants' ways of being in the world as well as their interpretive and narrative strategies and choices, narrative inquiry nonetheless takes participants' agency seriously and trusts that they are capable of finding meaning in and expressing their own lived experiences.

Approaching a subset of the Veterans History Project oral histories in our dataset through this lens, we sought to understand on a granular level how veterans' narrative constructions of trauma, suicidality, and the state differed across our four era cohorts. We were interested not just in what veterans experienced, but also in the specific narrative strategies and phrasing they made use of to describe their experiences, how their narratives connected past experiences to present understanding, and especially how their language patterns reflected shifting historical, cultural, and interpersonal contexts. To delve more deeply into how veterans from these different cohorts articulate their experiences of military service-related trauma, mental health struggles, and suicide, we analyzed the selected interviews in light of three open-ended questions:

- **Question 1:** How does the veterans' use of language—specific phrases or words—to describe experiences of trauma, mental health struggles, and/or suicidality reflect (or contrast with) evolving understandings of these issues?
- **Question 2:** How do the veterans' narrative choices (i.e., how they organize and order their story, what they choose to emphasize or de-emphasize within their telling, etc.) reveal their own understandings of trauma, mental health struggles, and/or suicide, and/or the meaning and values they attribute to these issues?
- **Question 3:** What do the veterans' use of language and other narrative choices suggest about how they understand the role of the state in preventing or mitigating veterans' trauma, mental health struggles, and/or suicidality?

While viewing the recordings of video oral history interviews, we took notes on salient descriptions, concepts, and arguments that spoke to one or more of the three questions, taking care to flag repeated topics and themes as well as historically or contextually specific or resonant word choices and phrasing. We also paid close attention to verbal and non-verbal cues that influenced participants' pacing, intonation, and affect, reflecting on how these things deepened the meaning of the narrative or indicated when participants were struggling to express emotionally fraught or 'taboo' thoughts or emotions. After viewing the videos, we read and compared the interview transcripts

with our notes and then added our interview notes and selected excerpts from participants' oral histories to a shared digital document. We then did another close reading of the notes and interview excerpts and compared the veterans' narratives to one another, engaging in a self-reflexive process of unpacking the text (Clandinin, 2006) to identify salient narrative frameworks and strategies and trace evolving understandings of trauma, suicidality, and the state across eras of service. Consistent with narrative inquiry methods, we do not seek to draw generalizable conclusions from them; instead, we attend to each narrative's particularities as a source of insight in its own right, and also as suggestive of discursive patterns and themes to focus on in future research.

This approach allowed us to access a broader range of direct and indirect references to veterans' understandings of trauma, suicidality, and the role of the state than it is possible to capture through any single research methodology. It also allowed us to analyze veterans' narratives on their own terms (Clandinin & Rosiek, 2019), creating space for veterans to be recognized as members of generationally-linked era cohorts *and* as diverse and multifaceted individuals. It is also consistent with our ethical commitment to acknowledging the profound and life-changing character of many veterans' experiences of military service, particularly those who have survived extreme conditions and traumatic events unfamiliar to most researchers.

## RESULTS

The study sample consisted of 49 US military veterans spanning four service eras: thirteen veterans from 1950–1964, twenty-four from 1965–1990, four from 1991–2002, and eight from 2003–2026. When veterans served in more than one era, we assigned them to the era of their longest service and/or the era they discussed most in their interview. Participants were predominantly male (93.9%); most were also (likely) Caucasian, though because of a lack of consistent demographic data, we cannot be precise about the percentage. Only 26% of the interviewees were classified in Library of Congress records as white; however, almost all of the 61.2% of veterans lacking demographic information also appeared to be White. Nonetheless, recognizing the limitations of subjective assessment of phenotypical characteristics, we have classified these veterans as race 'unknown.' Participants classified by the Library of Congress as Black/African American or Hispanic/Latinx each represent approximately six percent of the total interviewees, as did female veterans. The US Army was the most represented military branch (61%), followed by the Navy (14%), Marine Corps (14%), and Air Force (10%). When veterans served in more than one branch, we assigned them to the branch of their longest service. Demographic and military characteristics of the sample are presented in Table 1.

| DESCRIPTOR COMPONENT | 1950–1964 (*n* = 13) | 1965–1990 (*n* = 24) | 1991–2002 (*n* = 4) | 2003–2026 (*n* = 8) |
|---|---|---|---|---|
| **Race/Ethnicity** | | | | |
| Black/African American | 0 (0%) | 2 (8%) | 0 (0%) | 1 (13%) |
| White/Caucasian | 4 (31%) | 6 (25%) | 1 (25%) | 2 (25%) |
| Hispanic/Latinx | 0 (0%) | 2 (8%) | 1 (25%) | 0 (0%) |
| Asian | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Unknown | 9 (69%) | 14 (58%) | 2 (50%) | 5 (63%) |
| **Gender** | | | | |
| Male | 13 (100%) | 23 (95.8%) | 3 (75%) | 7 (87.5%) |
| Female | 0 (0%) | 1 (4.2%) | 1 (25%) | 1 (12.5%) |
| **Branch of service** | | | | |
| Army | 8 (61.5%) | 15 (62.5%) | 2 (50%) | 5 (62.5%) |
| Navy | 5 (38.5%) | 0 (0%) | 0 (0%) | 2 (25%) |
| Air Force | 0 (0%) | 5 (20.8%) | 0 (0%) | 0 (0%) |
| Marine Corps | 0 (0%) | 4 (16.7%) | 2 (50%) | 1 (12.5%) |
| Coast Guard / Space Force | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Accession type** | | | | |
| Drafted | 4 (31%) | 5 (21%) | 0 (0%) | 0 (0%) |

**Table 1** Demographic and Military Characteristics of the Sample by Service Era (n = 49).

| ANALYTICAL THEMATIC CODING MANIFESTATION | 1950–1964 (*n* = 13) | 1965–1990 (*n* = 24) | 1991–2002 (*n* = 4) | 2003–2026 (*n* = 8) |
|---|---|---|---|---|
| Mention trauma/suicide (self or others) | 7 (53.8%) | 15 (62.5%) | 4 (100.0%) | 6 (75.0%) |
| Mention shame or stigma | 2 (15.4%) | 3 (12.5%) | 1 (25.0%) | 1 (12.5%) |
| Mention of personal failure/weakness as factor | 1 (7.7%) | 1 (4.2%) | 1 (25.0%) | 0 (0.0%) |
| Mentioned reluctance to discuss struggles | 0 (0.0%) | 2 (8.3%) | 0 (0.0%) | 0 (0.0%) |
| Linked state resources to outcomes | 1 (7.7%) | 3 (12.5%) | 0 (0.0%) | 0 (0.0%) |
| Mention of accessibility to state resources | 1 (7.7%) | 0 (0.0%) | 0 (0.0%) | 1 (12.5%) |
| Mention of successful state intervention | 1 (7.7%) | 1 (4.2%) | 0 (0.0%) | 1 (12.5%) |
| Expression of state obligation for care | 1 (7.7%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| Mention of unsuccessful state intervention | 2 (15.4%) | 3 (12.5%) | 0 (0.0%) | 0 (0.0%) |
| Expression of failed state obligation for care | 1 (7.7%) | 2 (8.3%) | 0 (0.0%) | 0 (0.0%) |
| Other resiliency factors noted | 2 (15.4%) | 8 (33.3%) | 1 (25.0%) | 1 (12.5%) |
| Reference to race/ethnicity relevant to trauma | 1 (7.7%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| Reference to class/SES relevant to trauma | 0 (0.0%) | 1 (4.2%) | 0 (0.0%) | 0 (0.0%) |
| Reference to gender relevant to trauma | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| Reference to sexuality relevant to trauma | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) | 1 (12.5%) |
| Era data richness indicator | 8.6 | 8.4 | 8.5 | 8.4 |

**Table 2** References to Trauma, Suicide, and the State: Cross- Era Cohort Comparison (n = 49).

References to trauma, suicide, and the state are presented in Table 2. Mentions of trauma or suicide (self or others) were high in all groups: 7 (53.8%) from the 1950–1964 era, 15 (62.5%) from the 1965–1990 era, 4 (100%) from the 1991–2002 era, and 6 (75%) from the 2003–2026 era. These high rates are expected, as our sample was selected with a keyword search of "suicide" in the Veterans History Project database. Mentions of shame/stigma and reluctance were low across all groups. However, failure to admit or discuss these ideas does not positively indicate that these elements were not present, as reluctance to discuss something can lead to omission from an interview. Our method of querying pre-recorded interviews rather than directly surveying people prevented researchers from posing all questions to all veterans. Given this limitation, we present this analysis from a structured and contextual viewpoint.

Only Korean and Vietnam era cohort veterans explicitly mentioned failed state interventions, possibly suggesting that later-era veterans are less likely to perceive a failed state intervention. The Era Data Richness Indicator was calculated by summing the positive data collected from each era (1 for yes and 0 for no) and dividing each era cohort sum by the number of veterans in that cohort. These were: 112/13 = 8.6 (1950–1964); 202/24 = 8.4 (1965–1990); 34/4 = 8.5 (1991–2002); 67/8 = 8.4 (2003–2026). Similar scores across eras indicate consistent density of data—in this case number of data points per veteran in each era cohort. The similarity of these scores suggests that our research team maintained a consistent level of rigor and nuance in their analysis of interviews across era cohorts. This novel metric, an innovation developed to support this study's attempt to bring together epidemiological and narrative inquiry research methods, does not offer categorical guarantees of reliability; it nonetheless provides an additional tool by which to assess researcher bias.

## SHIFTING NARRATIVES OF VETERANS' TRAUMA, SUICIDE, AND THE STATE: A NARRATIVE INQUIRY LENS

### KOREAN WAR VETERANS' NARRATIVES: TRAUMA BY ANY OTHER NAME

Consistent with the absence before 1980 of a stable diagnostic framework for wartime psychological injury, our era cohort of Korean War veterans narrates combat trauma in sensory, embodied, and moral terms rather than through clinical vocabulary. For example, Mr. Fida, a Caucasian man who served as an Army Sergeant in the Aleutians during World War II and as a Navy Petty Officer during the Korean War before leaving service in 1953, narrates the trauma of witnessing his commanding officer's death and his own capture and torture in the Philippines through vivid, embodied language: the sniper's bullet, his own blood "gushing out," his cries for his mother and for God (Fida, 2015, 00:23:31). He later reveals decades of nightmares, intrusive memories, and a suicide attempt

(00:40:28). He frames this largely as a personal failing, suggesting that it was his own silence, rather than the war, that damaged his family: "Well, the worst thing of all was not to reveal—not to reveal my wartime experiences, because that—that ruined my marriage, I believe, not being a husband to my wife. That's the thing. If I hadn't—if I had been more considerate of my wife and children, I think everything would have been fine, but I didn't consider them" (01:08:22). Mr. Metcalf, a Caucasian man who served as a Navy Aviation Photographer's Mate in Korea from 1950 to 1953, similarly downplays his own suffering, insisting "the corpsmen had it worse," (Metcalf, 2009, 00:47:53) while describing the trauma of photographing mutilated remains, bankruptcy, a shipmate's suicide, two divorces, and his own suicide attempts as years spent in "a stress situation" (01:08:03). Neither veteran draws on diagnostic language; trauma is revealed through lived memory rather than labeled as a clinical condition.

This era cohort's narratives also allude to the state's responsibility to care for veterans, and at times criticize its failures to do so, but mostly in personalized terms. Mr. Fida recalls VA personnel initially dismissing his combat-related injuries (Fida, 2015, 01:01:04), but frames his delayed treatment as an individual hardship rather than a structural failure, without naming the state's responsibility for veterans' psychological wellbeing. Mr. Metcalf's critique is more pointed: he laments the absence of support for the military-to-civilian transition—"When I got out...there wasn't anybody to talk to because nobody understood and it seemed like nobody cared except me" (Metcalf, 2009, 01:17:33)—and his anger at the VA's initial refusal to grant him psychiatric care (01:23:09). Yet even this anger remains framed in individual, rather than collective, terms; he eventually finds VA psychiatric care decades later, wishing only he had found it 56 years ago (01:23:02). For both men, the state appears chiefly as the entity that sent them to war; the suffering that followed is narrated as a personal and moral struggle rather than a widely shared experience of institutional neglect. Reflecting the deeply gendered norms of military culture, which values emotional reticence and the stoic endurance of pain and adversity, this era cohort's trauma is endured quietly, without directly naming the compounding harms produced by state neglect.

## VIETNAM VETERANS' NARRATIVES: TRAUMA UNMASKED

Like their Korean War predecessors, our study's Vietnam era cohort narrates trauma in embodied and intensely individual terms. At the same time, their narratives reflect a tension between an emerging recognition of veterans' psychological suffering and their adherence to a deeply gendered military culture that downplays the harm caused by prolonged exposure to fear and violence. For example, Mr. Michael D. Harrigan, a Caucasian man who was drafted into the Army and served as an infantryman and battalion motor pool Sergeant in Vietnam from 1969 to 1970, recounts his combat experience through graphic, profane, darkly humorous language—relying on dehumanizing wartime slang and irony that perform toughness while revealing injury. He resists clinical terminology, describing combat's aftermath instead as having "really screwed me up" (Harrigan, 2010, 00:11:38) and "gone whacko" (00:50:50). He also frames trauma not as an aftermath but as an ongoing condition: his nonlinear, associative recollections embody his claim that he hasn't "slept since 1969" (00:45:47). Despite this, Harrigan repeatedly insists that the emotional desensitization produced by wartime conditioning—also a symptom of PTSD—can sometimes be functional in negotiating what he perceived as the dangers of civilian life. Harrigan nonetheless recognizes veteran suicide as a social phenomenon rather than an individual failing, observing of a friend's death and a broader generational pattern that "there's a reason" (00:17:37) behind rising suicide rates.

Mr. Thomas H. Hodge, an African American Marine who drove armored trucks in Vietnam from 1968 to 1971 after being drafted into the Army and electing instead to enlist in the Marine Corps, similarly describes how the cumulative nature of combat trauma—"this was every day"—produces emotional detachment ("your mind starts to get cold"; Hodge, 2002, 00:08:05). He is the first veteran in our study to explicitly invoke PTSD (00:35:06), drawing on its growing social recognition to frame his and his fellow veterans' postwar struggles as a collective response to war rather than a personal battle. At the same time, he regularly makes use of humor to minimize the psychological impact of the violence and fear that he experienced during combat.

Both men offer an explicit critique of the state that exceeds the largely implicit framing of the Korean War era cohort. Mr. Harrigan recalls a transition debriefing in which a colonel told returning soldiers to get used to "round-eyed women and flushable toilets," (Harrigan, 2010, 00:39:45) reading this dismissiveness as evidence that the military excels at producing combat-effective soldiers while remaining indifferent to their reintegration. He acknowledges the VA support he has since received, but frames it as reactive and insufficient, linking veterans' suffering—including a friend who lost both legs and later died by suicide—to systemic neglect. Mr. Hodge draws an even more pointed comparison, contrasting today's psychiatric response to mass-casualty events with the absence of any such support for returning Vietnam veterans: "nobody came" (Hodge, 2002, 00:23:37). He also criticizes state neglect of veterans, pointing out that the Vietnam

Wall [memorial] "doesn't show the veterans who died since the war" in VA hospitals or mental institutions (00:32:43). He offers a similar critique of veteran homelessness (00:33:18). He concludes that the state viewed him and his fellow soldiers as expendable: "The war is run by somebody in the higher up offices, we're just servants. We go out there and do what they tell us to do" (00:33:40). For this era cohort, trauma registers not as private misfortune but as a foreseeable cost of war the state failed to address.

## THE FIRST GULF WAR: NEW VOICES, TRANSITIONAL NARRATIVES

Reflecting the diversification of the post-Vietnam, all-volunteer military, the narratives of our Gulf War era cohort reveal how race, gender, sexuality, and political and religious beliefs shape veterans' understandings of trauma and state accountability during a period when therapeutic discourse was increasingly (but unevenly) entering the mainstream. Ms. Connie Spinks, a Black woman who enlisted in the Army Reserve in 2000, describes her experience of deploying to Korea, Kuwait, and Iraq before being medically separated in 2006 after being severely injured in a vehicular suicide bombing. Her narrative is inseparable from the intersecting identities she brings to it. She situates her enlistment within her family's military heritage and tradition of patriotism and her devout Christian faith, and narrates her recovery not through institutional mental health language but through that same faith: in her words, "everything happens for a reason" (Spinks, 2006). Interestingly, she also relies on gendered ideals of resilience rooted in both her understanding of Black womanhood and a masculine-coded military discourse that avoids overt expressions of individual suffering. Avoiding clinical language, she describes her emotional state during a difficult rehabilitation as "scared," "anxious," and "discouraged," (Spinks, 2006) but skips quickly over these negative emotions. Moreover, while crediting the state for providing post-injury medical care, she attributes her psychological recovery not to its resources but to the resilience she derives from her faith and family.

Mr. Marlow, a self-identified gay Caucasian man who served in the Navy aboard the USS *Dixon* (AS-37) during Operation Desert Storm, narrates witnessing a recruit's suicide in boot camp in highly sensory, emotionally candid terms. "The sound of his head hitting the concrete," he admits, "is something I'll never ever, ever forget" (Marlow, 2010, 00:05:51). Reflecting the ongoing stigmatization of mental health struggles despite PTSD's clinical recognition a decade earlier, he recalls a chaplain's dismissal of the suicide as the act of someone "weak" (00:06:23). Set against this backdrop, Mr. Marlow's candor about his own fear and vulnerability raises questions about how his identity as a gay man within a deeply gendered and homophobic military culture may have shaped both his attunement to others' suffering and his willingness to disclose his own. What's more, unlike members of earlier era cohorts, he explicitly articulates an expectation that the military should have provided psychological support after the suicide. "I expected them to… make sure we were okay psychologically" (00:06:08), he states—an expectation ultimately left unmet. He is similarly critical of the Navy's failure to hold a negligent officer accountable for the accident that injured him, observing that "the higher up you are, the less responsibility you have to take" (00:11:18). At the same time, he credits the state's postwar support through the GI Bill and a low-interest home loan as providing the foundation for the stability and relative ease of his civilian life (00:27:40).

## POST-9/11 NARRATIVES: TRAUMA AS UNRESOLVED PARADOX

Reflecting the ever-increasing diversity of the US military, our post-9/11 era cohort narrates trauma through a broad repertoire of clinical, political, and moral vocabularies. As with the previous cohort, their narratives highlight how each interlocutor's intersectional identities and worldviews shape how they recount their understandings of trauma, suicide, and the state.

Mr. Anoushian (categorized as race unknown), served in the Marine Corps as a combat engineer and field electrician and deployed to Afghanistan and Iraq from 2007 to 2014, narrates his repeated combat injuries—including one caused by an IED explosion—through a lens of operational competence rather than psychological vulnerability, framing his experiences within the Marine Corps ethos to "adapt and overcome" (Anoushian, 2016, 00:31:32). His self-identified conservative, patriotic worldview intersects closely with the Corps' traditionally masculine culture of stoicism: pride in service and national loyalty are narrated as inseparable from his refusal to dwell on fear or injury. His narrative structure breaks down, however, when he recalls a fellow Marine's death; visibly moved, he trails off into a protracted silence after stating "I think that's about all I want to say about that" (00:35:38). He also struggles to reconcile his enduring loyalty to the Marine Corps with his feelings of betrayal and loss after the medical board process that forced his separation, admitting "to this day I don't think I've gotten over [it]" (01:29:27). Notably, he never names mental health struggles directly; his distress surfaces obliquely through his insistence that he remains a Marine despite his separation, and through the frequent pauses and silences that communicate his grief at being deprived of a role that gave his life meaning. The state, in his account, appears primarily through the camaraderie

of the Corps, but also—more ambivalently—through the medical board process he experienced as simultaneously necessary and unjust.

A strikingly different story is told by Mr. Antal, a Unitarian Universalist minister who served in the Army Chaplain Corps from 2008 to 2016, deploying to Afghanistan as part of Operation Enduring Freedom. Reflecting on his own complex identity as a heterosexual white man who is also deeply religious and politically progressive (Antal, 2021, 00:58:14), he rejects the stoic reticence that often characterizes military discourse. Instead, describing his role as confidant to grieving and morally injured soldiers, Antal frames vulnerability and disclosure as a spiritual obligation. He understands veterans' suffering not solely in clinical terms, but through the language of "moral injury" (00:16:29) and "soul wound" (00:48:45). Of note, the latter term, a concept from Indigenous psychology that describes the collective, intergenerational psychological and spiritual harm that colonization and other sources of historical trauma have inflicted on American Indian and other Indigenous peoples (Duran et al., 2008; Gone, 2009), has only recently begun to appear in veterans' studies research (Grimell & Atuel, 2023). Antal's use of this term to emphasize the spiritual dimension of veterans' war trauma is a vivid example of how veterans' exposure to socially and culturally specific understandings of trauma influences their own narratives of trauma, suicide and the state—and further suggests that these narratives may evolve over time as veterans encounter new discourses that shape their own processes of meaning making.

Antal also offers the era cohort's most developed structural critique of the state. In a controversial 2012 Veterans Day sermon, he critiqued the American public's reflexive "support our troops" attitude and the "hero myth" (Antal, 2021, 00:29:05) that glossed over the individual and social costs of war. The Army's response—a reprimand for "politically inflammatory speech" and a recommendation for his early discharge—is read by Antal as further evidence that the military suppresses the truths it most needs to hear (00:38:11). Now a VA chaplain on a high-risk suicide review team, Mr. Antal articulates the cohort's most expansive view of state responsibility, extending it beyond clinical services to foreign policy and a public reckoning with the costs of war, lamenting that "we continue to have 18 to 20 veterans die by suicide each day" (01:13:08).

In striking contrast to Mr. Anoushian's narrative, in which his patriotism and adherence to the Marine Corps' deeply gendered culture mask an unspeakable sense of personal betrayal and loss, Mr. Antal's progressive spirituality compels him to break the silence and articulate a forceful critique of the social and moral costs of war. Read together, this era cohort's narratives further reveal how servicemembers' diverse religious and political worldviews provide them with distinct lenses for interpreting their experiences of trauma and the state's role in producing and responding to it.

## DISCUSSION

The results of our statistical and narrative inquiries reveal the persistence and salience of trauma among all of this study's era cohorts. They also reveal a clear but non-linear transformation in how US veterans narrate trauma, suicidality, and the role of the state. Veterans' narratives in particular reflect the co-evolution of clinical knowledge, popular discourse, social stigma, and lived experience, even as they show striking continuities in trauma's embodied, deeply personal character. Rather than a simple progression from silence to articulation, the findings suggest a more complex trajectory in which new vocabularies are layered onto enduring narrative patterns shaped by military culture and by veterans' multifaceted identities—race, gender, sexuality, religion, and political ideology.

One of the most significant patterns that is not discernible through our descriptive statistics, but is compellingly revealed through a narrative inquiry lens, is the gradual emergence of a shared language for trauma. Our deep dive Korean War narratives describe profound suffering through sensory detail and moral reflection, without clinical terminology—consistent with the absence of a stable diagnostic framework prior to PTSD's formal recognition in 1980, a shift that reframed trauma from individual weakness to a response to external stressors (Friedman, 2013; North, 2016). Our deep dive Vietnam-era narratives begin to bridge this gap, relying on vernacular and stigmatized language while reflecting growing awareness that war produces lasting harm. By the Gulf War and post-9/11 eras, the narratives we analyzed draw increasingly on emotional and therapeutic vocabularies, though not always consistently or critically; even in the most recent era cohort, clinical language coexists with—or is replaced by—frameworks of moral and spiritual injury, suggesting that the medicalization of trauma remains incomplete and unevenly adopted.

At the same time our statistical and narrative findings both suggest a striking continuity in trauma's embodied and enduring character. Veterans in all four era cohorts consistently anchor their narratives in vivid sensory memory and intrusive recollection, reinforcing longitudinal research on trauma's decades-long psychological dominance (Lee et al., 2020). What shifts is the meaning attributed to that experience. Earlier era cohort deep dive narratives frame trauma as a personal burden or moral failing; later narratives increasingly interpret it as a predictable—even structural—outcome of military service, reflecting epidemiological research that understands veteran distress as multifactorial rather

than reducible to a single diagnosis (Forkus et al., 2023; Goldstein et al., 2016).

Narrative structures, and their representations of temporality, evolve accordingly. Our deep dive Korean War narratives are largely linear and retrospective; our Vietnam narratives grow more fragmented and associative, reflecting trauma as an ongoing condition that disrupts temporal boundaries. By the Gulf War, our narratives became more integrative, embedding trauma within broader stories of identity and resilience. The deep dive narratives from our post-9/11 era cohort diversify further: the conservative Anoushian's strategic silence and depersonalization coexist with the progressive Antal's reflexive, morally expansive critique. These differences support narrative inquiry scholarship holding that individuals actively construct meaning through storytelling, drawing on—and reshaping—available cultural scripts (Martin, 2022; Schuman et al., 2019).

Quantitative trends in Table 1 and Table 2 did not suggest a clear linear progression in veterans' understanding of the state's obligations to care for those traumatized by war; in fact, veterans from the Korea and the post-9/11 era cohorts were the only ones who spoke directly about access to state-sponsored resources and successful state interventions to support veteran mental health. Of note, the earliest of the four era cohorts was the only one in which veterans directly referenced a state obligation to provide this kind of care. At the same time, Korean and Vietnam era cohort veterans were the only ones who spoke directly about unsuccessful state interventions and the state's failure to meet its obligation to care for veterans. However, our narrative inquiry analysis did discern a chronological pattern in how veterans narrate their understandings of the state. In our deep dive Korean War era cohort narratives, the state is largely implicit—the entity that sends soldiers to war and provides uneven post service care, but not yet conceptualized as responsible for psychological outcomes. Our Vietnam era cohort narratives articulate a more explicit critique, linking trauma to wartime policy and postwar neglect. By the Gulf War, expectations of institutional responsibility—particularly around training, medical care, and psychological support—are clearly visible in our era cohort narratives, though still individualized and unevenly applied. In the post-9/11 era cohort narratives, the state becomes a fully articulated moral and structural actor: Antal especially frames trauma and suicidality as products of militarism, institutional betrayal, and public disengagement, echoing scholarship that situates veteran suffering within broader political contexts and traces a shift from private tragedy toward collective responsibility (Fox, 2021; Roscoe et al., 2024).

This expansion of expectation produces a paradox: as veterans' expectations of state responsibility grow, so does their skepticism that the state can or will fulfill them. Even as they acknowledge expanded services, veterans continue to describe stigma, bureaucratic barriers, and moral injury within those same systems—consistent with research on the "trauma pitch" (Hooyer, K.C., 2022, "The Trauma Pitch," para. 2) and on how military norms of stoicism continue to reproduce stigma even within care-oriented systems (Neilson et al., 2020; Silvestrini & Chen, 2023).

A third pattern apparent in Table 2 and our narrative analysis is the persistence of shame and stigma for traumatized veterans. What becomes discernible only through our narrative inquiry, however, is the gradual transformation of understandings of stigma and especially how this is influenced by gendered norms. Ideals of stoicism and emotional control appear in deep dive narratives across all era cohorts; in earlier cohorts, however, they are expressed through silence and self-blame, while in later cohorts they coexist with greater openness. Our post-9/11 deep dive narratives articulate complex understandings of trauma while still withholding certain experiences or "containing" them in military, masculine, patriotic, or religious language—consistent with research on military culture's enduring influence on help-seeking and disclosure.

Finally, and extending beyond the existing literature, our findings suggest that veterans' narratives are shaped not only by historical period but also by their diverse identities, worldviews, and social positions. All four era cohorts—especially the Gulf War and post-9/11 eras—introduce perspectives shaped by race, gender, sexuality, religious, and political beliefs, revealing how these factors inform both exposure to trauma and its retrospective interpretation. These narratives complicate dominant clinical and media representations that treat veterans as a homogenous group, while also revealing the extent to which tropes of hero and wounded warrior fail to capture the diversity and nuance of veterans' lived experience.

## LIMITATIONS AND FUTURE DIRECTIONS

Our small sample of veteran narratives is drawn from a nonrandom, and non-probabilistic dataset returned by a single keyword search ("suicide") of the Veterans History Project archive. This was a deliberate methodological choice appropriate to an initial study; however, it likely excluded many oral histories that included relevant discussions of trauma and mental health struggles. For these reasons, our findings are not statistically generalizable. Caucasian male veterans are also likely overrepresented in our

sample, which introduces a race and gender selection bias that limits how broadly our preliminary conclusions can be applied. Our dataset's lack of consistent demographic data also prevented us from assessing how factors such as race, ethnicity, class, gender, sexuality, education, or rank shaped veterans' understandings of their own experiences. Nor could we address the issue of how being drafted versus volunteering for service may shape veterans' narratives; this is a distinction we anticipate future research would reveal to be important.

From a narrative inquiry perspective, this study's principal limitation lies in the varied format and context of production of the narratives we analyzed. Because many interviews were conducted years, and in some cases decades, after the veteran completed their service, it is difficult to determine to what extent the historical context in which they went to war influenced their narrative choices or how their understanding evolved in the years leading up to the interview. Also, since most interviews aimed to preserve a record of military service rather than veterans' psychological state, many questions emphasize the external facts of a veteran's time in uniform over their internal processing of traumatic experiences. Our dataset also includes interviews conducted by interviewers of varying skill, who asked rather different questions of different participants. This limits our ability to state with authority whether the differences in veterans' narratives identified by this study accurately represent the diversity of understandings and narratives among various generations of veterans, or to what extent they are a product of interview variability.

It is also important to recognize that the veterans in our sample might have had more to say on the topics of trauma, suicide, and the state if interviewers had focused specifically on these topics. We nonetheless found that themes of trauma, mental health, suicide, and the state surfaced organically in many interviews, a finding that reinforces narrative inquiry's emphasis on the agency of individuals in shaping their own narratives through the ways they reframe questions and select stories and themes to highlight—as well as through the topics they choose to avoid.

The findings of this paper suggest several promising directions for additional research. Future studies might examine more systematically how clinical and therapeutic language has been adopted, adapted, or resisted by veterans across different contexts—including how diagnostic categories like PTSD interact with alternative frameworks, such as moral injury or spiritual suffering. This would require delving more deeply into how veterans' narratives intersect with public discourse, policy debates, civic engagement, and veterans' religious and political worldviews. It would also require closer analysis of how veterans' multifaceted social identities shape their narratives, seeking to further distinguish among veterans according to race, class, gender, sexuality, and citizenship status, as well as rank, branch, and military occupational specialty—and whether their service was conscripted or voluntary. These studies should center the experiences of women, LGBTQ+ veterans, and veterans of color, whose perspectives remain underrepresented in both clinical and narrative research. More research is also needed to explore how institutional interactions, particularly with the VA, shape not only treatment outcomes but also veterans' narrative and meaning-making processes over time.

## CONCLUSION

Although its findings are suggestive, this paper provides preliminary but provocative support for our assertion that veterans' narratives must be understood as dynamic constructions shaped by historically specific and constantly evolving forms of clinical knowledge, cultural norms, and social contexts, as well as by veterans' own complex and multifaceted identities and positionalities. By placing these narratives in dialogue across temporally distinct era cohorts, this study contributes to a deeper understanding of how trauma, suicidality, and the state are not only experienced but also continually reinterpreted over time.

Some of this study's insights were made possible by our decision to use research methods that are not usually paired with one another to begin to answer a common set of questions. Descriptive statistics provided us with a broad overview of our sample and the ability to compare era cohorts across time as well as across specific themes/data points. This provided a structure and context against which narrative inquiry could be used to delve more deeply into individual interviews that featured themes and trends present across the complete sample, to highlight when they emerged in time as well as how they evolved across cohorts. This allowed for a unique breadth and depth within a single study, and allows us to begin to ask questions about the extent to which historical context may be related to how veterans narrate their understandings of trauma, suicide, and the state.

## DATA ACCESSIBILITY STATEMENT

The secondary data source utilized in this study is available via the public collections of the United States Library of Congress Veterans History Project repository. Coded structural spreadsheets generated during this analysis are available from the corresponding author upon request.

## NOTES

1 The Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published in 1980 by the American Psychiatric Association, marked the formal introduction of Post-Traumatic Stress Disorder (PTSD) into codified clinical diagnostic frameworks, establishing an objective criteria paradigm shift away from combat exhaustion terminology.

2 We grouped veterans by 'era cohort.' Unlike the VA's cohort classification scheme, we use the broader term 'era cohort,' to constitute groups of veterans of the same general age who experienced military service in the same conflicts and/or general historical period. Each cohort encompasses the era's major military conflict (Korean War, Vietnam War, etc.) and continues until the onset of the next significant armed conflict. When veterans served in more than one era, we assigned them to the era they discussed.

## ETHICS AND CONSENT

This study was submitted for review and approved by the Institutional Review Board (STUDY 00002111) as meeting the criteria for NHSR Self-Determination. The research conforms entirely to established protocols for the use of secondary archived human subjects data from public repositories.

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## COMPETING INTERESTS

The authors have no competing interests to declare.

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