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Commentary on "When a Soldier Commits Suicide in Iraq: Impact on Unit and Caregivers"

The Impact of Soldier Suicide on a Base in Afghanistan: Lessons for Prevention and Postvention

J. John Mann, M.D.

The striking increase in suicide rates in the Army and the Marines, the two military services that have borne the brunt of the fighting in Iraq and Afghanistan, has raised the question of why has this increase taken place when the Navy and Air Force have been spared and so has the civilian sector in the United States. When there have been increases suicide rates that have been unexpected, such as the dramatic increase in teen suicide rates reported in the 1980s, the first answers came from newspaper articles and were based on speculation and mostly quite wrong. The next set of answers came from carefully conducted psychological autopsy studies (Bridge, Goldstein, & Brent, 2006; Brent et al., 1999; Shaffer et al., 1996) and showed the critical relationship of suicides to psychiatric illness that was not mentioned in most newspaper articles and generally not expected to be such a major factor in the vast majority of cases. That relationship had been reported in adults but not previously been studied in teens and young adults. To date there has not been a similar psychological autopsy study of a consecutive series of Army and Marine suicides employing structured diagnostic instruments in third-party interviews with family and other informants, such as those in the same unit (Kelly & Mann, 1996). Another approach, which can be informative, is an idiographic study of individual suicides. Such an approach can identify factors that may be missed in a highly structured approach that focuses on known risk and protective factors. The suicides in the U.S. military have several dimensions that are different from those in the civilian sector. First, civilians are rarely subject to the stress of deployment and combat. Second, there is the degree to which a soldier's unit can be supportive and make a difference by acting like a second family. The paper by Carr gives us a sensitive and eloquent glimpse into the world of the Army unit and its health care system. Carr was the treating psychiatrist for a young soldier who died by suicide while in a combat zone in Iraq. He shot himself in the chest while alone in his quarters and left a suicide note.

Several observations highlight similarities to suicide in the civilian sector while

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many others illustrate just how different things are in the Army in a combat zone. Similar to the civilian secttor is the impact on members of the same unit, such as guilt (the soldier in whom the deceased had confided about his suicidal feelings who then chose to protect the confidence), the sense of shock and disbelief, the shaken confidence of the combat stress team whose leader and psychiatrist had treated the deceased for major depression right up to the suicide, and the sense of being second guessed by the reviews of the circumstances of death that followed the suicide. What was different was that the family was not mentioned in the report because it seems the author did not have any contact with the family or with anyone who did. They are mentioned tangentially in a speculation over the risk of a lawsuit. What is also different is the unit's response and the effect of Army-defined responses. The creative "walk-abouts" of the Combat Stress Control (CSC) unit (Hamaoka, Benedek, Grieger, & Ursano, 2007; Benedek, Ursano, & Fullerton, 2007) that allowed for informal observation, informal referrals of others or self-referral, and imparting information were something that could not be readily used in situations like college campuses, schools, or large corporations because such units do not exist in those settings. Perhaps they have a role in the initial response to major civilian tragedies like the attack on World Trade Center? A subject of postvention in survivors of a suicide, meaning the family and friends of someone who dies by suicide, is dealing with shame, stigma, and guilt (Hoge et al., 2009). In this case, Carr describes how only members of the soldier's own unit were allowed to attend the memorial service which was done partly to avoid glorifying the suicide. In fact, that could have been avoided by inviting the entire base and giving a lot of support to the soldier's unit, using the occasion to both honor the soldier's memory and to stress the importance of seeking help and becoming better gatekeepers for Army buddies. A related aspect of providing care was the concern about not evacuating everyone who feels stressed. Examples are given of effective management "in the field." It was certainly illuminating to learn that no inpatient psychiatric facilities exist in Iraq and that the decision to admit a patient involves up to a week's delay, with Army buddies maintaining a watch over the "patient." This presents risks and challenges that are quite different in the civilian sector, and careful review of the outcomes of treatment under these conditions is a vital aspect of military medicine that needs full documentation. The creative idea of letting the soldier carry his weapon but disabling it so it could not fire was a method of means prevention without the humiliation of having the weapon confiscated. Another approach was to restrict availability of live ammunition for entire unit while they were on combat patrols or missions. The military wants the best treatment for its soldiers and at the same time wants to avoid degrading the fighting capacity of the unit. We would like to think there is a way to fully meet both goals. One is reminded of the Old Testament where many potential soldiers were sent home before deployment or battle because they had married within the past year, had a new home or vineyard, or were afraid. One wonders then, who would be left? The soldiers who fight our battles are all afraid of combat, but somehow they overcome their fear. However, if they need help, we need to provide it. And we need to know that the help we offer is evidence-based. Knowing that help is available and that there is no shame in needing it will make units more effective in the field. Remembering to support the caregivers and avoid destructive second-guessing with the benefit of hindsight are also crucial. Another major difference from the civilian sector is that the caregivers of a suicide then have to take care of the survivors: the rest of the unit, the medical care team that attended the suicide, the behavioral health team or combat stress control unit (themselves), and the other soldiers on base. Carr's article points out that 13 soldiers were affected in terms of psychopathology and treatment as a likely consequence of

one soldier's suicide. Therefore, his article needs to be part of corpus of observations on the best way of managing events after a suicide on a combat base. We must move from descriptive papers like this one to designing and conducting systemic observational studies and then evaluating defined interventions to determine what works best. Opinion must give way to the facts gained from studies, and then studies must set treatment and prevention procedures.

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