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

A Soldier's Suicide: Understanding its Effect on Fellow Soldiers

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More people die by suicide each year around the world than by all wars, genocide, and interpersonal violence combined (World Health Organization, 2009). Alarmingly, recent figures suggest that U.S. Army Soldiers, who are trained to kill others in the defense of their country are now more likely to die by their own hand than by that of an enemy combatant (U.S. Army, 2010). The U.S. Army and National Institutes of Health have acted swiftly in response, launching a multitude of research initiatives aimed at understanding the causes of suicide among Soldiers and identifying the most promising directions for intervention efforts. For example, the U.S. Army and National Institute of Mental Health recently partnered to launch the Army STARRS project, a multi-site, $50 million study aimed at identifying modifiable risk and protective factors for suicide among Soldiers (see www.ArmySTARRS.org). The hope is that such efforts will reveal malleable causal risk factors that can be targeted by interventions that ultimately will decrease the rate of suicide among Soldiers.

A topic that has received far less research attention, both in the military and more broadly, is the impact that suicide has on those close to the decedent. The excellent article by Dr. Carr appearing in this volume sheds light on this important topic and provides rich detail about how the effects of a suicide unfold over time. In this article, Dr. Carr reports on the tragic suicide of a Soldier while deployed to Iraq, and he describes in fine detail the impact that the Soldier's suicide had on those around him, including members of his unit, other Soldiers on his base, and the health care professionals who provided both mental health care prior to his suicide attempt and medical care immediately following his attempt. Although Shneidman (1973) famously suggested that each suicide affects six people, more recent empirical work suggests that the actual number directly affected by a suicide death varies depending on the definition used but may be as high as 60 per suicide (Berman, 2011). Dr. Carr's paper provides a vivid report not only of how many fellow Soldiers are affected by each suicide, but of the various ways such a death can impact those around the fallen Soldier. There are many valuable aspects of Dr. Carr's paper, but I would like to highlight the three that I think are especially noteworthy.

First, the use of a case description provides extremely rich information about this complex clinical issue. Most prior studies on suicide and its effects take a hypothetico-deductive approach and use controlled de-

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signs with quantitative assessment and data analysis in order to test investigator-derived hypotheses. Such an approach is necessary to advance the scientific understanding of this issue, but provides somewhat limited opportunities to observe the phenomenon of interest up close as it unfolds over time. In utilizing a case study, Dr. Carr's article also provides valuable information about several of the unique aspects of suicide among Soldiers. One of the most significant differences between suicide in civilian versus military contexts is that in the military, and especially among those in theater, the environment already is one of outstandingly high stress, violence, and uncertainty and one in which the mission must continue with little time for mourning or postvention. This is illustrated powerfully in Dr. Carr's article in the description of the physician who attempted to revive the Soldier and after his death had to continue his duties with the Soldier's blood stains on his boots. In the civilian context, it is rare that someone would be attempting to revive a friend or colleague after an attempted suicide (except perhaps in remote geographic regions where the patient may be well known to the medical professional attempting to revive him or her), and unimaginable to think that the medical professional would have to continue about their work after the event wearing their blood-stained garments. Yet, this is something that our Soldiers are asked to endure while they continue on with their assigned combat missions. This level of detail brings into clear focus the extremely challenging situations our Soldiers endure on a regular basis that may contribute to high levels of psychological distress.

Second, the use of a case study also provides a clear clinical illustration of several recent scientific findings obtained from studies of large groups. For instance, recent research has shown that: (a) more than 75% of people who die by suicide see a health provider in the year before their death, and 45% do so within the month before their suicide (Luoma, Martin, & Pearson, 2002)—this was true with the Soldier described in this case study; (b) as many as 66% of people who die by suicide explicitly tell others about their suicidal thoughts prior to their death (Cavanagh et al., 2003)—this Soldier told others about his suicidal thoughts; (c) nearly 80% of patients who kill themselves explicitly deny suicidal thoughts/intent in their last communication before killing themselves (Busch, Fawcett, & Jacobs, 2003)—this Soldier assured his clinician during their last meeting that he would not act on his suicidal thoughts and denied having them anymore; and (d) the risk of suicidal behavior is greatly increased in the presence of multiple psychiatric disorders, with depression being the strongest predictor of suicidal thoughts and problems with agitation and behavioral control the strongest predictors of acting on suicidal thoughts (Nock et al., 2010a)—this Soldier was diagnosed with major depression and also had problems with anger management. This article paints a real-life picture of how these factors play out in an individual case. On one hand, it is reassuring to see the consistency between findings from quantitative and qualitative studies. On the other hand, both types of studies continue to highlight the enormous limitations in our understanding of and ability to predict and prevent, suicide.

Third, this article highlights the need for improved, evidence-based methods not just for predicting and preventing suicide, but also for dealing with the immediate aftermath in a way that meets the needs of those affected, while maintaining/maximizing the functioning of the force. Current methods of suicide prediction rely largely on asking people if they are thinking about killing themselves and if they say "yes," keeping them in a locked hospital setting until they convince those around them that they no longer intend to do so. There are of course many limitations to relying so heavily on a person's self-report, but this is at present virtually all we have. In the current case, there were risk factors (e.g., presence of major depression, anger problems) and more immediate warning signs (e.g., talking about wanting to die by suicide); however, the Soldier was able to

convince those around him that he was not really going to act on his suicidal thoughts. There is a tremendous need for the development of objective indicators of suicide risk, such as genetic/biological markers or cognitive/behavioral markers. There also is a serious need to better understand which of the many prevention programs currently in use are actually effective, and which postvention programs can decrease the risk of ongoing distress and psychopathology among those affected by suicide.

Recent research offers important points of departure in each of these areas. Indeed, there is evidence that objective measures of a person's genetic (Mann et al., 2006) and behavioral (Nock et al., 2010b) data can improve the prediction of subsequent suicidal behavior. There is some evidence for prevention programs employing physician education, training of gate-keepers, and means restriction (Mann et al., 2005). There also is a growing body of research on the science of grief in general (Bonanno, 2010) and on the effects of patient suicide on clinicians in particular (Hendin et al., 2000). As research proceeds down these and other avenues, it will be important to continue to draw on qualitative case studies, such as the excellent one presented by Dr. Carr, and to continue to work to our greatest possible ability to protect from self-harm the many Soldiers who so bravely protect all of us from harm by others.

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