Army Suicides – Plus ca change, plus c'est la meme chose

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New reports about record-breaking numbers of Army suicides are alarming but not surprising: 128 suicides in 2008, and a suicide rate which has finally exceeded the national average (20.2 per 100,000 for the Army, vs. 19.5 per 100,000 for the USA). These statistics are the inevitable by-product of a national mental health care policy which remains in crisis, largely because it has been based upon an "evidence-biased" literature which continues to undermine the quality and integrity of medical care.

With respect to soldier suicides, three recent studies are especially compelling:

Study #1
R.D. Gibbons, C.H. Brown, K. Hur, S.M. Marcus, D.K. Bhaumik, and J.J. Mann, "Relationship Between Antidepressants and Suicide Attempts: An Analysis of the Veterans Health Administration Data Sets," *American Journal of Psychiatry* 164 (2007): 1044-1049.

This was a retrospective cohort analysis of Veterans Health Administration datasets involving the identification of all veterans who received treatment for "new onset depression" in 2003 or 2004. Using E-codes (numbers) to identify all patients with depressive illness, the research team then stratified these subjects into two groups: recipients of antidepressant drug therapy, vs. non-drug recipients. Next, the same E-code database was reviewed in order to identify the depressed subjects who made suicide attempts during the same time interval. Finally, the rates of suicide attempts were calculated for each treatment group.

Although the investigation was marred by numerous *flaws in study design, one finding was particularly remarkable: the use of SSRI medication (e.g., fluoxetine, sertraline, paroxetine) was associated with a higher rate of suicide attempts, relative to those who remained drug free:

	exposed to SSRIs	NOT exposed to SSRIs
suicide attempt rate per 100,000 patients	364	335

*among them: a) exclusion of anyone who was not followed for at least 6 months; b) failure to report raw data (outcomes) for 52,959 subjects who received treatment with more than one kind of antidepressant (a likely event, in the context of treatment-emergent suicidality); c) exclusion of suicide attempts resulting in care outside the VA system

Study #2

M. Valenstein, H.M. Kim, D. Ganoczy, J.F. McCarthy, K. Zivin, K.L. Austin, K. Hoggatt, et al, "Higher-risk periods for suicide among VA patients receiving depression treatment: Prioritizing suicide prevention efforts," *Journal of Affective Disorders* 112 (2009): 50-58.

In this retrospective cohort study, researchers associated with the Department of Veterans Affairs, the University of Michigan, and Columbia University identified the outcomes of more than 880,000 VA patients who received treatment for depression between April 1999 and September 2004. Suicide rates were compared for five different "12-week, post treatment" periods. For each patient, outcomes were compared according to a total observation period of 60 weeks (5 x 12 weeks).

Findings revealed the highest rate of suicides in the immediate aftermath of psychiatric hospitalization (568 suicides per 100,000 person years), in the immediate aftermath of a brand new exposure to antidepressant drug therapy (210 suicides per 100,000 person years), or *other antidepressant start (193 suicides per 100,000 person years); and in the 12 weeks which followed changes in drug dose (154 suicides per 100,000 person years). All of these suicide rates were higher than the general "background" rate of suicide for the entire 60 month study period:

Relative risks for suicide (first 12-week period relative to weeks 13 through 24):

post-hospitalization	1.9 times higher risk
after antidepressant start	1.8 times higher risk
after dose change	1.4 times higher risk

The researchers concluded with the following cautionary note: "To have the greatest impact on suicide, health systems should prioritize prevention efforts following psychiatric hospitalizations." What was alarming, however, was the cautious tone of another recommendation: "*If resources allow*, closer monitoring may also be warranted in the first 12 weeks following antidepressant starts, across all age groups."

[emphasis added -- Apparently, if there are insufficient resources, these authors suggest that a higher suicide rate becomes permissible.]

* defined as: switch to new antidepressant; addition of a second antidepressant for combined therapy; or initiation of an antidepressant within 6 months of treatment with a different drug

Study #3

M. Raja, A. Azzoni, and A.E. Koukopoulos, "Psychopharmacological treatment before suicide attempt among patients admitted to a Psychiatric Intensive Care Unit," *Journal of Affective Disorders* 113 (2009): 37-44.

Investigators affiliated with a major hospital in Rome performed a retrospective, case-control analysis of all adult patients (aged 18 or older) admitted to their Psychiatric Intensive Care Unit between April 2004 and March 2007. Cases (n = 109) consisted of all subjects admitted for treatment following a serious suicide attempt. Non-suicide-attempt admissions (n = 489) comprised the controls. All subjects were screened at admission for baseline psychiatric symptoms, overall level of functioning, and treatment history within the preceding three months.

Relative to non-suicide controls, suicide attempters were more likely to have received antidepressants and benzodiazepine drug therapy within the 3 months of hospitalization:

	suicide cases	non-suicide cases
% taking antidepressant	39%	16%
% taking benzodiazepines	43%	23%

In an effort to discern a possible bias according to treatment indication (i.e., were antidepressants and benzodiazepines given to patients with impending suicidality), the researchers compared the level of mood and anxiety symptoms among suicide attempters, relative to their medication status. This analysis revealed no difference in baseline depression or anxiety (no confounding by psychopathology). A similar analysis was done for the non-suicide attempters. This comparison, too, revealed no confounding by baseline severity of mood symptoms. In other words, the researchers could not detect any bias according to which antidepressants had been disproportionately dispensed to patients who were *already suicidal*.

In concluding their paper, the Italian researchers summarized their key findings as follows:

- 70% of the individuals who attempted suicide (cases) had received drug therapy in the 3 months prior to the serious event

- suicide attempters were more likely to have received antidepressants or benzodiazepines than the non-suicide attempters, but this was not biased by baseline psychopathology

"Taken together, the results of this study suggest that the use of antidepressants in patients with mood disorders is not associated with a reduction of suicide attempt rate. Furthermore, from the present study, it is not possible to exclude that antidepressants or benzodiazepines may induce, worsen, or precipitate suicidal behaviors in some patients, especially in those affected by mood disorders with Depressive or Mixed features…. When prescribing antidepressants, clinicians should warn patients of the possible risk of suicidal feelings, thoughts or behavior and monitor patients closely."

Further thoughts:

According to a June 2008 article in *Time* magazine ("America's Medicated Army"), Army officials attribute the epidemic of suicides primarily to ***failed relationships***. This, ironically, may be far more accurate than the federal government would now like to believe. The story of soldier suicide is indeed a story of failed relationships, but not of the kind which the Pentagon and Congress are likely to perceive. These fractures in human-human relatedness, and in healer-patient relationships, include:

- a failure to relate the rate of suicides to the essential cause of emotional suffering and spiritual overwhelm …
  [fill in the blank: betrayal by the former President and fabricated intelligence; betrayal by war profiteers; betrayal by the FDA; etc etc]

- a failure to relate the rate of suicides to outdated and inappropriate guidelines and practice parameters (i.e., VA and DoD health care policies which continue to be based upon a sham medical literature, marred by undisclosed trial data; biased study designs; ghost writing; redundant publication; and censorship)

- a failure to relate the rate of suicides to the continuing use of pharmaceutical industry shills (key opinion leaders or KOLs, such as those appointed to the Blue Ribbon Panel on Suicide Prevention in June 2008)

and

- a failure to relate the rate of suicides to the DoD's "pharmaceutical imperative" --- a longstanding mandate which restricts and often overtly punishes the use of non-drug approaches (even when the latter are more effective and less toxic than drugs).

According to Colonel Kathy Platoni, Chief Clinical Psychologist for the Army Reserve and National Guard, the latest rise in suicides is "terrifying" but:

"We do not know what is going on."

Last year's story in *Time* magazine gave every indication that *someone* should have realized what was going on – 40% of the suiciding soldiers in 2006 and 2007 had received psychotropic medications prior to death, but it seems that no one was willing to seriously consider the role of these drugs in the tragic outcomes.

One might hope that 2009 could be different, but it will take much more than new research grants for studies of soldier suicides (e.g., the recent contract awarded to the National Institute of Mental Health to determine "what's killing the troops"). It will take a willingness to completely re-think the role of chemicals on and off the battlefield, and how it is that government officials, military leaders, and health care professionals might improve their numerous failed relationships.

Further References:

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